DOCUMENT RESUME

ED 478 239 PS 031 393

AUTHOR	Fenichel, Emily, Ed.
TITLE	Culture and Caregiving: Goals, Expectations, & Conflict.
INSTITUTION	Zero to Three: National Center for Infants, Toddlers and Families, Washington, DC.
ISSN	ISSN-0736-8038
PUB DATE	2003-05-00
NOTE	73p.
AVAILABLE FROM	Zero to Three: National Center for Infants, Toddlers, and Families, 2000 M Street, NW, Suite 200, Washington, DC 20036-3307. Tel: 800-899-4301 (Toll Free); Tel: 202-638-1144; Fax: 202-638-0851; Web site: http://www.zerotothree.org.
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Bulletin of ZERO TO THREE: National Center for Infants, Toddlers, and Families, 2003.; v23 n5 May 2003
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS
DESCRIPTORS	American Indians; *Child Care; *Child Caregivers; *Cultural Awareness; Cultural Pluralism ; Cultural Relevance; *Infants; Mental Health; Mexican Americans; Models; *Toddlers
IDENTIFIERS	*Cultural Sensitivity; Latinos

ABSTRACT

"Zero to Three" is a single-focus bulletin of the National Center for Infants, Toddlers, and Families providing insight from multiple disciplines on the development of infants, toddlers, and their families. This issue focuses on the goals, expectations, and conflict in the relationship between culture and child caregiving and other care services. The articles are: (1) "Caregiver Goals and Societal Expectations" (Casper, Cooper, Finn and Stott); (2) "From Rocks to Diamonds: Mining the Riches of Diversity for Our Children" (Barrera); (3) "Listening to the Voices of Families: Thoughts, Hopes, and Fears in a Latino Community" (Stott and Halpern); (4) "Making New Choices Possible: Understanding Differences in Infant Feeding Practices between Latina Mothers and Anglo Health Care Providers" (Clark); (5) "A Relational and Sociocultural Approach in Services to a Mexican Family across Three Generations" (Rios Munoz); (6) "Talk to Your Baby: Honoring Diversity while Practicing from an Evidence Base" (Van Horn and Segal); (7) "Joining American Indian Systems of Care: The Complexities of Culturally Appropriate Practice" (Mayo-Willis and Hornstein); (8) "Cultural Models for Early Caregiving" (Finn); (9) "Barriers to Achieving Change: Dynamics of Social and Economic Differences in an Early Head Start Program" (Hallock); (10) "When Cultures Clash in Court: Expanding Understanding and Building on Hope" (Lederman); and (11) "Creating a Public Early Childhood Education System for a Pluralistic Parent Constituency: The Challenge of First 5 LA" (Cooper). Two additional articles describe an infant mental health evaluation process, and changes brought about by a new director at a child care center. Regular departments of the bulletin list Zero to Three publications, videotapes, and on-line resources, and announcements about Zero to Three staff. (HTH)

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ED 478 239

ZERO TO THREE®

May 2003
Volume 23 No. 5

Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families

Culture and Caregiving: Goals, Expectations, & Conflict

Cultural Models for Early Caregiving

Strategies for Responding to Cultural Diversity

Listening to the Voices of Families

Cultural Change Across Three Generations

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Editor's Note

This issue of *Zero to Three* represents a level of collaboration unusual even for this publication. We have *four* Guest Editors, one from each member institution of the Four College Early Childhood Consortium. **Virginia Casper** is at **Bank Street College** in New York City; **Fran Stott** is at **Erikson Institute** in Chicago; **Renatta Cooper** represents **Pacific Oaks College** in Pasadena and Seattle; and **Cathy Finn** is at **Wheelock College** in Boston.

The Consortium was created in the fall of 1993. Each of the four institutions that make up the consortium is concerned with the societal needs of young children and their families, and the wide spectrum of early care and education. Faculty of the four institutions have collaborated on presentations at national meetings and in publishing. Indeed, it was when Virginia, Fran, Renatta, and Cathy were planning a presentation on "Caregiver Goals and Societal Expectations" that we developed the idea of expanding the presentation into an issue of *Zero to Three*.

As long-time readers of *Zero to Three* know, past issues of the Journal have focused on the impact of culture on early development; cross-cultural perspectives on particular aspects of early care and education; and the methodologies most appropriate for studying very young children and their families in the context of their culture. (See, for example, the issues of *Zero to Three* for April 1990; June 1992; February/March 1994; October/November 1994: April/May 1995; December 1995/January 1996; June/July 1998; December 1999/January 2000; February/March 2002; September 2002; and January 2003.) This issue explores tensions that occur as individual and group (or family and program) assumptions about child development and existing child-rearing practices meet face to face.

It is not easy to explore such tensions, even among colleagues or friends who know each other well. Thus it was with great care that the four co-editors crafted a call for articles that would provide insights about ways in which families and program staff influence each other's caregiving goals and practices. The outcome was another level of collaboration, as a multicultural, multidisciplinary group of contributors from the field proposed ideas for articles, discussed them with the editors, wrote drafts, and revised them in order to communicate more clearly to the broad, diverse readership of *Zero to Three*.

We hope that you will find this issue of *Zero to Three* thought provoking. Please share your reactions, experiences, and ideas through a Letter to the Editor. We are eager to continue the conversation.

Emily Fenichel

Dr. Laura Dittmann, who died May 27 at her home in College Park, touched the lives of many educators in the field of early care and education. She wrote manuals and pamphlets on early childhood development and education, including one titled "Finding the best care for your infant or toddler," which was produced with ZERO TO THREE and published by the National Association for the Education of Young Children. Dr. Dittman retired from the University of Maryland in 1983, after teaching for 16 years in the Department of Human Development in the College of Education. Her student, Abbey Griffin, recalled, "She was a true mentor – one who guides through experience and knowledge. She did not just teach; she built relationships. Her teaching was an example of shared learning. To learn with her was to share a passion, to bring theory alive through personal experiences and stories. The stories she told her students often referred back to the national child care network built with funding through the Lanham Act to care for the children of working mothers. She helped us believe in the possibility of regenerating that kind of national commitment to quality care for all children."

ZERO TO THREE

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ISSN 0736-8038
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2000 M Street, Suite 200
Washington, D.C. 20036-3307
Tel: (202) 638-1144
Customer Service: 1-800-899-4301
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Cover photography: Nancy Guadagno

PHOTO: MARILYN NOLT

CAREGIVER GOALS AND SOCIETAL EXPECTATIONS

VIRGINIA CASPER, *Bank Street College of Education, New York City*

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We live in a pluralistic society in which culture is increasingly seen as encompassing dynamic and flexible dimensions of human life. These dimensions include our perceptions and assumptions as well as the realities of our ethnic, racial, and linguistic backgrounds, all influenced by the barriers and opportunities of social class. Culture informs caregivers' values and traditions and the ways in which they guide their children's development. There are multiple experiences and outcomes that caregivers imagine for their children, and various caregiving strategies, arrangements of childhood activities, and styles of communication exist to meet these goals and objectives. Too often, what might feel "right" in a given interaction with a family member (gleaned from education/ training or intuition or both) is constrained by our own experiences (Nugent, 1994) and the meanings we give them. In this issue of *Zero to Three* we have chosen to examine some tensions that occur as individual and group assumptions about child development and existing child-rearing practices meet face to face.

Tensions

As we each consider families and their practices primarily through our own experiential lens, how are we to interpret caregiving behavior that conflicts with the ideologies of our particular agency, profession, strongly felt values from our own upbringing, or even existing state and federal policies? We may see a tension between any one of the goals/strategies of a program and those of the staff in that program, or alternatively, with the goals/ strategies of parents whose children attend the program. Whether it is at the therapeutic, educational, or policy level, the infant–toddler family interdisciplinary field is moving to new planes of awareness. Indeed, the complexity of such multilayered tensions can feel dazzling and overwhelming at times. Nevertheless, rather than see such moments only as challenges, we are also increasingly likely to view them as imperatives to learn about ourselves as well as what others bring to the table.

Finally, some practitioners feel a strain between what it takes to create the authentic relationships necessary for a partnership that fosters the long-term development of families, and the increasing pressure to demonstrate "short-term" evidence-based outcomes designed with specific standards of care in mind. We believe it is possible and necessary to document our ongoing work with very young children and families, but that we need clear and strategic ways to formulate and document our goals, observations, conversations, and interventions. The articles we have chosen for

this issue bring together examples of essential approaches that can be integrated into one's daily practice.

Theory and Research

Just like the humans who created them, time and place constrain prevailing theories of individual child development. The vast majority of theories of child development used in the West, for example, reflect an emphasis on individuation and use of the relational partner as a secure base for exploration. The problem is not in their usefulness for understanding the meaning and dynamics of a particular group, but rather in their notions of universality and lack of specification of their ethnocentric bias. We believe that in addition to this body of work, which continually needs to be rethought and critiqued, we need also to turn to models that draw our attention to the social and cultural forces that influence human development. Bronfenbrenner's (1979) ecological model and the more recent work of cultural psychologists (e.g., Cole, 1996; LeVine, et al., 1994; Rogoff, 1990; Schweder, 1991; Super & Harkess, 1986) offer a culturally aware and contextually based framework for an understanding of early development and parenting across cultures, subcultures, and parenting contexts. These models also help us understand how changing local values, traditions, and activities of various groups and subgroups create within-group differences. We are often surprised, for example, at the ways in which within-group differences—differences in acculturation, generations, and seemingly slight language or geographical variations—can be more salient than across-group differences. More child development research needs to organize variables or consider the context of early development in ways that help practitioners reconceptualize differences in child behaviors or child rearing (Rogoff & Angelillo, 2002).

More child development research needs to organize variables or consider the context of early development in ways that help practitioners reconceptualize differences in child behaviors or child rearing

What Else Can Guide Our Practice?

We have culled some of the key messages from each of the articles in this issue and present them here as an introduction.

* **Engage in respectful and skilled dialogue** in which everyone may give up a little in order to arrive at a "3rd Space" (Barrera) from which to move forward.

* **Join into a system of care** (Mayo-Willis & Hornstein), **using the baby's behavior** to address child rearing and developmental concerns—supporting, not replacing, healthy development within the framework defined by the community.

***Join with the family to observe different ways in which communication occurs** (Van Horn & Segal), commenting on the strengths of the infant's behavior and exploring parental perceptions and behaviors through questions and descriptions of behaviors—to learn the "hows" and "whys" of the baby's behavior from the parent's point of view.

* **Establish relationships of trust and communication with families** (Rios Muñoz), forming an alliance, whenever possible, with multiple generations within a family.

* **Examine one's assumptions, including the possibility of different understandings of the meaning of outcomes or "change"** (Hallock).

* **Review, repeat back, and explore a family member's ideas about a caregiving practice, discussing possible choices, including one's own understanding of current and accepted practice** (Clark). In this way, one is acknowledging openness to variation in caregiving and a respect for the historical and cultural foundations of community practices, before also providing "new" information about the issue (e.g., feeding). Through this exchange of information, ideas are shared and caregivers can make informed decisions.

* **Discuss basic issues of quality care or services with people who are not in the early childhood profession** (Cooper). We need to help shift popular perception on these issues and build public will for meaningful support of young children and families. We need to help others move beyond rhetoric about the value of children to the allocation of adequate resources for the youngest members of society.

* **Consider incorporating ethnographic approaches into one's work (Finn).** Consider how caregivers' beliefs and values contribute to frameworks or "models" of caregiving that are inherently understood and operationalized by members of their social group. Ethnographic methods of observation, interview, and recursive reflection can assist practitioners in their quest to understand the motivations of caregivers and to support them in meeting their goals for their children.

* **Systematically listen to the voices of families in order to hear their thoughts, hopes, and fears** (Stott & Halpern). One way to help program staff gain a better understanding of the families they serve is to hold a series of focus groups with participating family members and codify families' voices in a form that is accessible to all program staff.

Ways of Thinking and Being

It is not possible to come up with a list of approaches and habits of mind that could even approximate complete cultural responsiveness—nor, in such a rapidly changing world, would it be desirable. Everyone must cull his or her own solutions that will be a source of support through the necessary periods of disequilibrium that are inherent in questioning one's work.

Two issues came to our minds as we reviewed the articles in this issue. One of our most cherished resources is the *time* necessary to have the kinds of relationships necessary to work with infants, toddlers, and their families. This is self-evident at the level of the professional–family–child relationship. But time also plays a crucial role in the creation of a treasured group of colleagues—where trust leads not just to safety, but also to open, honest, and at times painful dialogue with each other—with whom to talk about what constitutes culturally responsive practice. For us—a group of infancy-related professionals coming together through the Four College Early Childhood Consortium—this kind of ongoing dialogue helps us keep our practice honest. Our work in this country and abroad, with infants, young children, families, and communities, as well as with adult students and at the policy level, has provided rich examples from which to examine ways of thinking and being with difference—in our lives and in our work. It's true that our belief systems contain us. The goal is to develop greater awareness of our belief systems and thus be better equipped to reflect on how they influence us in our work. Ultimately, belief systems, while they contain us, should not constrain us. Rather, they should allow us to clear our paths in the world of young children and families.

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From Rocks to Diamonds:

Mining the Riches of Diversity for Our Children[1]

Isaura Barrera
University of New Mexico, College of Education, Albuquerque, New Mexico

Photo: Marilyn Nolt

"I want the best for my child." "I want my baby to learn what she needs to learn to become a competent adult." These themes are spoken in many languages by caregivers and parents alike. Society agrees on the need to nurture children to become "good citizens." It is only when the visions and meanings attached to these words are examined that differences become evident (Carlson & Harwood, 1999). What is envisioned by the words "what she needs" or "good citizens?" What meanings are attached to "the best" and "competent adult?" The diversity reflected in the interpretation and practices associated with these words ranges from slight variation to outright contradiction. Yet, it is this very diversity that carries the key to nurturing children's unique identities and skills in ways that promote successful participation in communities.

Differences can be seen as obstacles (rocks) or as treasures (diamonds) to be mined. Both aspects have something to offer. The rock, or obstacle, aspect of differences serves as a wake-up call alerting us to the fact that we need to turn off our autopilot approach to others and examine what is happening more closely. The diamond, or treasure, aspect offers us previously unimagined options that enhance our own perspective as well as that of others. Fletcher and Olwyer (1997) pointed out that accepting contradictions and mining them for their potential strengths expands our valuing of ourselves as well as our valuing of others.

The nature of differences as potential obstacles to the collaboration and communication that underlie strong nurturing has been relatively well explored in the literature (Cintas, 1995; Delpit, 1995; Lynch & Hanson, 1998). Less well explored has been the nature of differences as treasures.

at a glance

- The Skilled Dialogue approach helps practitioners address cultural differences.
- Respect, reciprocity, and responsiveness characterize Skilled Dialogue.
- Anchored Understanding of Diversity involves understanding how caregiving practices make sense in context.
- The skill of 3rd Space breaks the deadlock between either–or choices.
- Practitioners can use these approaches to help diverse children and families strengthen and sustain their identities and integrity across environments.

[1]Adapted from Barrera, Corso, & Macpherson (2003). *Skilled Dialogue: Strategies for responding to cultural diversity in early childhood*. Baltimore: Brookes Publishing Co. (www.brookespublishing.com). Copyright © 2003 by Paul H. Brookes Publishing Co. All rights reserved. Used with permission.

To explore only the nature of obstacles that diversity can pose without also and simultaneously exploring the gifts disguised within those obstacles can easily become overwhelming, like continually asking questions without ever taking the time to find answers.

The Skilled Dialogue approach (Barrera & Corso, 2002; Barrera, Corso, & Macpherson, 2003) seeks to help practitioners recognize both the potential obstacles and the hidden gifts inherent in cultural differences. Table 1 shows the three qualities that characterize Skilled Dialogue—respect, reciprocity, and responsiveness— and the two skills that support these qualities: Anchored Understanding of Diversity and 3rd Space. Anchored Understanding of Diversity focuses on the rockier side of differences, sometimes referred to as culture bumps (Barrera & Kramer, 1997). 3rd Space addresses the conversion of these bumps into resources and gifts (i.e., diamonds). This article focuses on these two skills, particularly the skill of 3rd Space, which is the less familiar of the two.

Anchored Understanding of Diversity

The skill of Anchored Understanding of Diversity emphasizes the need to move from holding differences at arm's length, as something we cannot relate to or can relate to only negatively, to engaging with them in ways that unveil how they make sense. For example, when a family "caters" to a child's every need (in the eyes of caregivers) rather than promoting autonomy in expected ways, how can caregivers come to respect that choice as a child-rearing practice that makes sense (i.e., that has validity in its own context)? How can the caregivers come to a place where they can say "Aha, I understand" and, even more important, "I might consider doing the same thing were my experiences and values similar to the family's."

It is important to note that perceiving how child-rearing practices make sense does not necessarily mean approving of them or ceasing efforts to protect children from harmful interactions with adults. It does, however, mean listening with compassion to families and treating them with respect even in such situations.

Anchored Understanding of Diversity is intentionally particular and reciprocal. It is designed to generate compassionate knowledge that "... arises not from standing back in order to look at, but by active and intentional engagement in lived experience" (Groome, 1980, p. 141). It is, for example, one thing to talk generally about families with practices different from our own and another thing entirely to personally carry on that discussion over time with those families. Two types of contexts are created through such extended face-to-face interactions. First, previously held knowledge acquires a personal context—it becomes about someone whom we actually know. Secondly, such interactions give concrete form to conceptual images so that we can say, "Oh, so that's what having differing perceptions of time actually looks like." Within these experiential contexts, previously held categories and assumptions can be challenged (e.g., "I thought that this family had no concept of time!").

Remen (2000) recounts a story that illustrates in a striking manner the distinction between knowing that is experientially anchored and knowing that remains unanchored. She tells of a young physician who had an elderly Navajo woman as her patient. The woman's daughter brought her to the physician's clinic regularly for more than 2 years. During that time, the daughter and the physician did all the talking and the old woman "simply watched and listened" (p. 68) as the physician treated her for a variety of diseases. "She gave her antibiotics for an infection of the urine, managed the old woman's diabetes, ...digitalized her and reversed her incipient heart failure, revised her diet in keeping with the limitations of a liver that was barely functioning. She ordered many lab tests" (p. 68). Sometime after the Navajo woman died, the physician received a call from a researcher who was investigating American Indian medicine traditions and had been told about a great medicine woman. When he contacted the woman's family, he learned "that she [the physician] had taken care of their mother and met with her many times. She knew their mother well. She would have the answers he needed" (p. 69). Remen then recounts the physician's reflections on this experience many

TABLE 1: CRITICAL INCIDENT ANALYSIS SHEET

Incident Description:	Anchored Understanding of Diversity	3rd Space
Respect	*Key Principle*: Acknowledge range and validity of diverse perspectives	*Key Principle*: Stay with the tension of differing perspectives
Reciprocity	*Key Principle*: Establish interactions that allow equal voice for all perspectives	*Key Principle*: Develop opportunities for equalizing power across interactions
Responsiveness	*Key Principle*: Communicate respect and understanding of other's perspective	*Key Principle*: Create response(s) that integrates and accesses strengths of diverse perspectives

years later: " 'I think of her sitting there all those months, watching me shuffling my papers and tracking my lab data and knowing what she knew. I wonder what was going through her mind. What I would give for even one hour with her now, to ask her any of my unanswered questions...Or simply to ask for her blessing'" (p. 69).

As caregivers and as a society, we are often the recipients and generators of a large volume of information *about* the young children and families with whom we interact. Similarly to the physician in Remen's (2000) story, we can describe family dynamics and developmental concerns; we may even be able to describe the values associated with their culture. But, if asked to describe a particular child or family, could we talk about their personal hopes and dreams? Could we define what *success* or *family* meant to them? Our ability to answer these questions reflects the degree to which we possess Anchored Understanding of Diversity in relation to an individual family.

Respecting families does not necessarily require that we admire the behaviors they exhibit; it does require that we understand how those behaviors make sense from a cultural as well as a personal perspective. Otherwise we may, like the physician in Remen's story, simply believe that they have nothing of relevance to contribute (i.e., that they have no reality outside of our own cognitive framework). We may not, for example, admire the behavior of a caregiver who sets no firm bedtime for a 4-year-old child. Anchoring our understanding of that behavior, however, would first require us to become curious as to the cognitive and emotional framework within which that behavior makes sense to that caregiver. What understanding of how the world works underlies her intent? Why does she perceive this behavioral option as more appropriate than the option we might value (e.g., a set and consistent bedtime)?

By posing a series of questions such as these, Anchored Understanding of Diversity prompts us to explore not just the differences we encounter, but also, and more importantly, the meaning that underlies them. (See Table 2 on p. 11 for a partial listing of such questions; see Barrera et al., 2003, for a more complete listing). In the case of a caregiver who encounters an apparently passive mother who seems uninterested in implementing recommended activities, for example, anchoring our understanding of diversity might yield the following insights:

1. Cultures understand who holds critical knowledge in different ways. Some cultures believe in "social distribution of knowledge" (i.e., that critical knowledge need not be personally possessed because it is "available and accessible through social networks" (Moll and Greenberg, 1990, p. 323).
2. The mother's behavior, initially perceived as passive or disrespectful might actually be rooted in a different understanding of the role of experts, one that considers it disrespectful to interfere in their work. Alternatively, it may be rooted in previous experiences of having her knowledge invalidated by other caregivers.
3. Perhaps the mother's behavior does, in fact, express disrespect for "help" that does not promote greater competence in negotiating her daily environment!

The acquired insights are, however, only byproducts of the primary intent of Anchored Understanding of Diversity to: express respect (i.e., acknowledge others' experiences and competence), establish reciprocity (i.e., increase opportunities for equal voices for families and caregivers), and act responsively (i.e., acknowledge one's own limitations and other's unique skills and contributions).

3rd Space

Once our understanding of diversity is anchored, what then? How can identified contradictions in values and beliefs be mined for the treasures they may hold? How can their unique aspects be integrated without one diminishing the other? The second skill associated with Skilled Dialogue—3rd Space—seeks to respond to these questions as it grows out of and builds on Anchored Understanding of Diversity.

3rd Space is actually both a skill and a mindset that focuses on creatively reframing contradictions into paradoxes. As a mindset, 3rd Space supports respectfully holding divergent and sometimes seemingly contradictory views in one's mind at the same time without forcing a choice between them. EuroAmerican Normative Culture[2] commonly polarizes reality into either–or dichotomies (Stewart & Bennett, 1991; Hall, 1977). In contrast, the skill of 3rd Space invites practitioners to shift from a dualistic and exclusive perception of reality to an integrative, inclusive perspective that focuses on the complementary aspects of diverse values, behaviors, and beliefs. This shift breaks the apparent deadlock between either–or choices by opening the possibility a 3rd (or 4th, or 5th) choice. For example, how can a parent's apparently passive (or resistant) behavior (i.e., not "cooperating" with caregivers) complement the caregiver goal of increasing desired cooperation[3]?

Using 3rd Space strategies helps caregivers (a) mine the richness of both perspectives, and (b) promote respect and reciprocity by not excluding one perspective in order to privilege another, thus capitalizing on the potential of diversity to enrich and expand. The following characteristics of 3rd Space give some indication of just how it does this:

1. Reality in 3rd Space is non-dichotomous; it is better described as a spectrum than a continuum. In relation to diverse perspectives, this aspect of 3rd Space introduces

[2] Term used by Barrera et al. (2003) to refer to the institutionalized norms against which cultural diversity is defined. It is a term chosen over other more common terms such as "White" or "European" to highlight the fact that it refers to institutionalized cultural norms rather than to the personalized cultural frameworks of particular individuals.

[3] One answer might involve modeling cooperation with the mom rather than trying to change her behavior. Another might involve reframing her behavior as complementing, rather than contradicting the caregiver's.

the possibility of conceptualizing these perspectives in non-polarized ways (see Footnote 3).

2. There are always at least three (or more) choices in 3rd Space. This aspect of 3rd Space requires creatively generating alternatives beyond the obvious (e.g., passive and engaged, in the example above). Paradise (1994) gives an interesting example of a third perception in her article on Mazahua mothers and children, in which she described a form of interaction she termed "separate-but-together" (p. 160).
3. "The whole is more than the sum of the parts." The idea that two or more perspectives, no matter how seemingly contradictory, can be somehow combined or integrated is a core theme to 3rd Space. In 3rd Space, differences are understood to be complementary rather than divisive. Boundaries can serve both as distinctions and as points of contact that, like the poles of a battery, generate constructive rather than destructive tension when connected.

The following analogy further illustrates 3rd Space prior to discussing more specific applications to interactions between families and caregivers. Imagine actual rooms in physical space. We can perceive this space in several ways. From a *singular space* perspective, there is, literally, only one room: the one I'm in. I believe that my room (i.e., view or perspective) is the only one that exists and I can neither see nor imagine other views. They are nonexistent or totally discounted. If I am told about them, I do not accept them as "real." Events and interactions can only take place in "my" room.

From a *dualistic space* perspective, I realize that mine is not the only room. I accept other views as real, but place them

TABLE 2: SELECTED QUESTIONS FOR EXPLORING POTENTIAL CULTURE BUMPS

	Cultural Dimensions		
Curricular Areas	**Sense of Self (Identity)**	**Funds of Knowledge**	**Perceptions of Power**
Personal–social	How does my sense of self play out in social interactions and settings? Who do I believe I am? (individual identity) How do others see me? (attributed identity)	What is my understanding of social roles and rules? What do I consider appropriate behavior? What degree of importance do I give to individual? to community?	What has been my experience of power vis-à-vis larger society? peers? authorities? others? In what situations do I feel competent/powerful? unskilled/powerless?
Sensory–cognitive	How do I understand identity? What characteristics do I believe are essential to a self? What is relationship of self to larger environment ("my place in the world")?	What are my values/beliefs concerning: —ways to best teach/learn —how the world works —ways to best solve problems and make decisions What is my worldview?	How would I define power? How do I believe that it is acquired and exercised? What do I believe confers power on a person? To what degree am I conscious of my own power?
Communicative–linguistic	Relationship of language to identity How does my language and communication maintain my sense of self? Name	Language(s) I speak Roles and rules for use of language and communication Relative value of verbal and non-verbal communication Literacy	How do I express/maintain power through language? What status is given to language(s) I speak? What has been my experience as a speaker of this language(s)?

Parents Talk About Infant Emotional Health and Development

The Early Head Start National Resource Center (EHS NRC) at ZERO TO THREE was recently funded by the Head Start Bureau to engage in a variety of activities designed to support Early Head Start (EHS) programs in their efforts to address issues related to infant mental health. The initiative included gaining an understanding of what EHS parents understand about infant emotional health and development. The EHS NRC worked with a firm, Belden Russonello & Stewart (BRS), to conduct focus groups among a wide variety of EHS parents and others who would qualify for the program.

Focus groups allow for in-depth discussion and exploration essential to understanding how individuals—in this case low-income parents of babies and toddlers—approach and deal with a complex and personal issue. In 2002, BSR conducted 17 focus groups in Phoenix; Washington, DC; New Orleans; Rapid City, South Dakota; East Lansing, Michigan; and Seattle, WA. There were groups for Caucasian, African-American, Latina, Native American, and Asian parents; there was also a mixed racial/ethnic grandparents group.

Analysis of the discussions revealed that:

- The concept of emotional health is familiar to EHS parents.
- Parents understand the link between emotional and cognitive growth in general terms.
- Nurture trumps nature.
- Parents from all groups generally agree that neglect, drug and alcohol use by adults, and physically and verbally abusive behavior can contribute to a baby or toddler's emotional problems.
- Most parents in the groups believe that babies can develop emotional problems, including depression.
- Many—but not all parents—can identify telltale signs of possible emotional problems in infants and toddlers.
- Although they answered many questions similarly, different racial and ethnic groups in the research believe that there are some key differences in their approach to child rearing and emotional development.
- Young fathers in the groups say they are trying to be more involved in their babies' emotional development than their own fathers were.
- Age and generational differences center around the amount of affection shown to children and "old-fashioned" discipline.
- EHS participants said they would turn to pediatricians, and EHS staff when dealing with their infants' emotional growth, but they expressed some distrust of pediatricians and felt that not all EHS staff could help them with emotional issues.

BSR reports that the focus groups suggest that most of the parents enrolled in EHS whom they met have a fundamental understanding about the emotional development of babies and toddlers and an open attitude about learning more.

outside of my space (i.e., exclude them from my room). I am, so to speak, in one room and persons different from me are in a different room. Events and interactions can take place only in one or the other room (e.g., my way or your way, either this or that, right or wrong). In dualistic space, there is no common space. We cannot meet unless one or both of us moves: I must leave my room (i.e., comfortable space), or you must leave yours, or we must both leave our rooms and go to another "neutral" room. If I hold a "both-and" perspective, we each remain in our separate rooms, side by side yet unable to integrate our respective rooms (i.e., perspectives).

In contrast, a 3rd Space perspective invites us to consider the possibility that we could integrate our diverse perspectives. It asks the question: How can we both end up in the same space without moving? It challenges us to realize that it is the wall between us, not our respective positions, that keeps us from occupying common space. Walls are different from boundaries. Boundaries are markers of space and identity. They may generate diversity bumps, but they do not obstruct our view and can be permeable when we wish them to be. Walls, on the other hand, are opaque and impenetrable. Depending on their size and thickness, walls exclude and result in diversity clashes or, sometimes, outright crashes. A wall is often a boundary that has fossilized over time, becoming hard and dense in response to repeated assaults on it. From a 3rd Space perspective I realize that if we can lower or remove the wall between our rooms, we can both be in the same room without having to move.

Removing walls, however, is never the same as erasing differences. To say there is no difference is to fail to acknowledge identity; to fail to recognize that we were just talking to a child, to Mary, or to a man, for example. 3rd Space thinking invites us to give equal voice to our differences (i.e., uniqueness) as individuals, as genders, or as cultural communities while simultaneously remembering our similarities. A toddler, for example, is distinct from an adult, yet remains a human being with similarities to all other human beings regardless of age. Categorization is different from compartmentalization. As Palmer (1998) says so well, "We split paradoxes so reflexively that we do not understand the price we pay for our habit. The poles of a paradox are like the poles of a battery: Hold them together, and they generate the energy of life; pull them apart, and the current stops flowing. When we separate any of the profound paired truths of our lives, both poles become lifeless as well. Dissecting a living paradox has the same impact on our intellectual, emotional, and spiritual well-being as the decision to breathe in without ever breathing out would have on our physical health" (p.64).

Strategies Associated With 3rd Space

Developing 3rd Space, like acquiring Anchored Understanding of Diversity, is best learned through practice. It may not be something we clearly understand until we experience it. Barrera et al. (2003) discuss various strategies for practicing this skill.

Table 3 identifies these strategies for developing 3rd Space perspectives and thus transforming rocks into diamonds. Through this process of anchoring our understanding of the culture bumps that we encounter, similarities and differences (i.e., boundaries) are clearly established. Finding differences, however, can be a source of tension. Oftentimes when tension exists, our first reaction is to minimize this tension rather than to let it be and explore its colors and contours. In creating 3rd Space, however, it is important to stay with the tension even when significant contradictions are identified. Suspending judgment and delaying resolution are critical preconditions for the emergence of 3rd Space options.

Finding differences can be a source of tension. Oftentimes when tension exists, our first reaction is to minimize this tension rather than to let it be and explore it. It is important to stay with the tension, suspend judgement, delay resolution, and reflect on what might be creating the tension.

It is important for caregivers to reflect on what might be creating the tension they are experiencing. The first set of strategies addresses this aspect of 3rd Space. By listening and observing, without rushing to resolve these differences, caregivers can start the process of examining what treasures might emerge. Sometimes the treasures are inherent in the contradictions themselves and emerge as these are integrated and our vision is expanded, in the same way that creativity is inherent in the integration of order and chaos. Other times, the treasures are almost tangential, as a deeper understanding of our own and others' projections comes about (i.e., as we become clearer about our own and others' fears).

A second set of strategies for creating 3rd Space revolve around building reciprocity to ensure that power is equalized across interactions. These strategies involve perceiving all parties in an interaction as both learners and teachers. A frequent block to the creation of 3rd Space options is the perception that one party has more to learn than to teach. Here again, the teaching can be direct (i.e., we learn new information) or it can be indirect (i.e., we learn how little we truly listen to diverse viewpoints!). Caregivers can use comments or ask questions to reflect how two differing viewpoints may be simultaneously "right" or how they may complement each other (e.g., "Oh, I understand how that could be," "You know, that is really helpful to what I think needs to happen").

A final set of strategies to create 3rd Space involves co-constructing responses that access and integrate the strengths of diverse perspectives (e.g., tapping existing family skills as well as suggesting new ones). This is, in many cases, the least familiar and most challenging strategy. The identification of common space without requiring that we move out of our comfort zones tends to be a less familiar strategy in Euro-American Normative Culture than the strategy of forcing a choice between zones.

Practitioners may be able to use analogies to elicit responses that are able to capture the complementary aspects of multiple perspectives (e.g., the glass is both half empty and half full). There is no need to choose between these seemingly contradictory realities if we attend to the glass rather than to the water line. It is important that caregivers work to find multiple "third choices" until a choice that seems best to all parties is found. It is important to note that the purpose of conceptualizing and creating 3rd Space options is not to make decisions. Rather, it is to create a common space within which the probability of making optimum decisions is heightened.

The following example comes from a group of Head Start staff who were asked to select a situation to which they would like to apply the idea and skill of 3rd Space. They immediately chose to focus on their recent experiences with Martha[1], a mother whose 4-year-old son was exhibiting aggressive and hyperactive behavior (e.g., throwing chairs, hitting students, running around the room). The staff had developed a behavior management program that was meeting with some success on site but they could not get Martha to agree to use it at home. Her response to them was "As long as he doesn't burn the house down, I'm OK with his behavior." They added that Martha was an older single mom who worked two jobs, one of which was a night shift at a juvenile detention facility.

The first step for this group of practitioners was to achieve Anchored Understanding of Diversity of this situation. They especially focused on identifying possible positive intents underlying Martha's behavior. After extended discussion, they decided that they could accept Martha's perspective as valid (even if undesirable) if the choices Martha was currently perceiving were to either ignore her son's behavior or to end up hitting him as a result of her own frustration and limited energy. For the first time, the group felt that they could respect this mother's decision. Even though they disagreed with her range of choices, they could now respect her need to avoid physical violence.

But how could they begin to create 3rd Space? The two existing spaces—the space in which the mother was inattentive to her son, and the space in which the staff felt that forcing compliance was their only choice—both had significant drawbacks. The ensuing discussion was a prolonged one. Even though the staff could now respect Martha, their negative judgment of Martha's behavior seemed to preclude the possibility of creating inclusive 3rd Space options. When the question "What could you find to compliment this mom on

[1] This example is taken from an actual case. The names have been changed and the circumstances altered slightly to maintain confidentiality.

in this situation?" was raised, an answer was slow in emerging. Finally, one staff member said "We could compliment her on how well she has encouraged her son to become self-reliant." The change in their energy after this statement was palpable. A 3rd Space perspective in which Martha's behavior (now reframed as supportive of self-reliance) could be integrated with the staff's desired behavior (nurturing relational and social skills) began to develop. The staff could now approach Martha as an equal partner who was providing one part of the desired whole. The staff, thus, reframed their interactions as "adding to that part" rather than contradicting or trying to erase it. As a result, they reported that they no longer felt the need to approach Martha from a "We need to fix this" approach and, instead, could approach her from a sincere "How can we help you?" position. The final outcome remained uncertain, but the shift in perspective promised to move them toward a more positive outcome than their initial one, which had been "Implement our behavior management program at home or we will no longer be able to serve your child." Table 3 provides a format for examining the different aspects of establishing Skilled Dialogue in this and similar situations. Additional examples of 3rd Space options, both general and early childhood-specific, along with references that can be helpful in developing reframing skills are provided by Barrera et al. (2003).

When we fail to honor culture as an integral part of identity... we lose dreams and unique funds of knowledge...

Table 3: Strategies for Creating 3rd Space Options

Qualities That Characterize Skilled Dialogue	Specific Strategies
1. *Respect*: Stay with tension of differing perspectives	*Strategy 1.1*: Listen/observe without judgment * Sample statements: "I see" "That's interesting" Nonverbal indicators of interest or curiosity *Strategy 1.2*: Identify specific contradictions or culture bumps
2. *Reciprocity*: Develop opportunities for equalizing power across interactions	*Strategy 2.1*: Shift focus of conversation to "equalize" participation * Sample questions/statements: Share "vulnerable" statement such as "I'm not sure of just where to go next." Use analogy/metaphor familiar to other, or unfamiliar to both *Strategy 2.2*: Reframe contradictions into complementary perspectives *Sample questions/statements: "What if we are both right?" Suggest how others' behavior or perspective might complement what you are advocating
3. *Responsiveness*: Create a response that integrates and accesses strengths of diverse perspectives	*Strategy 3.1*: Explore/create responses that incorporate multiple perspectives * Sample questions/statements: Use analogies (e.g.,"half-full/half-empty" glass analogy) Come up with "third choices"; continue until you find one that seems best to all parties

Conclusion

Failing to mine the riches of our diverse identities has implications that reach far beyond early childhood. Palmer's (1998) observation is a critical one: "When we forget who we are [because there is insufficient validation of our identities] we do not merely drop some data. We 'dis-member' ourselves, with unhappy consequences for our politics our work, our heart" (p. 20).

Both biological and sociological data expand our understanding of what these "unhappy consequences" can be. Quinn (2001) quotes a poignant statement: "Natalia Sangama, a Peruvian elder who lives in Pampa Hermosa, northeast of Lima, Peru, reveals: 'I dream in Chamicuro, but I cannot tell my dreams to anyone. Some things cannot be said in Spanish. It's lonely being the last one'" (p. 9). When we fail to honor culture as an integral part of identity, we lose more than words and behavioral rules, we lose dreams and unique funds of knowledge that unlock perspectives otherwise unknown.

Data on the need to recognize and preserve diversity at the biological and environmental levels are a red flag for the need to recognize and preserve diversity at the human and cultural levels (and vice versa). At a human developmental level, data on the consequences of discontinuous or invalidating early environments also speak to the "unhappy consequences" of "dis-membering" who we are. Brazelton and Greenspan (2000) name the need for "experiences tailored to individual differences" (p. 159) and for "stable, supportive communities and cultural continuity" as "irreducible needs" (p. xx) that every child must have to "grow, learn, and thrive" (p. ix). Koplow (1996) addresses the "importance of an educational environment that reflects a child's experiences" (p. 17). And finally, Janoff-Bulman (1992) identifies three fundamental assumptions necessary to our optimum functioning: the world is benevolent, the world is meaningful, and the self is worthy. Though she does not discuss culturally invalidating experiences as experiences that potentially shatter these assumptions, the connection is not far-fetched.

The material we've presented in this article is designed to help practitioners support diverse children and families to "re-member" who they are (i.e., strengthen and sustain their identities and integrity across environments in ways that are life-enhancing).

Ultimately, dialogue in the skilled sense in which it is defined in this article cannot be prescribed. Every situation, no matter how similar or different to another, will have its own unique complexities. The strategies suggested by the Skilled Dialogue approach can, however, provide a means to explore those complexities in ways that are respectful, reciprocal, and responsive. These qualities emerge when "we embrace the promise of diversity, of creative conflict, …[and] face one final fear —the fear that a live encounter with otherness will challenge or even compel us to change our lives.…Otherness, taken seriously, always invites transformation, calling us not only to new facts and theories and values but also to new ways of living our lives—and that is the most daunting [challenge] of all" (Palmer, 1998, p. 38).

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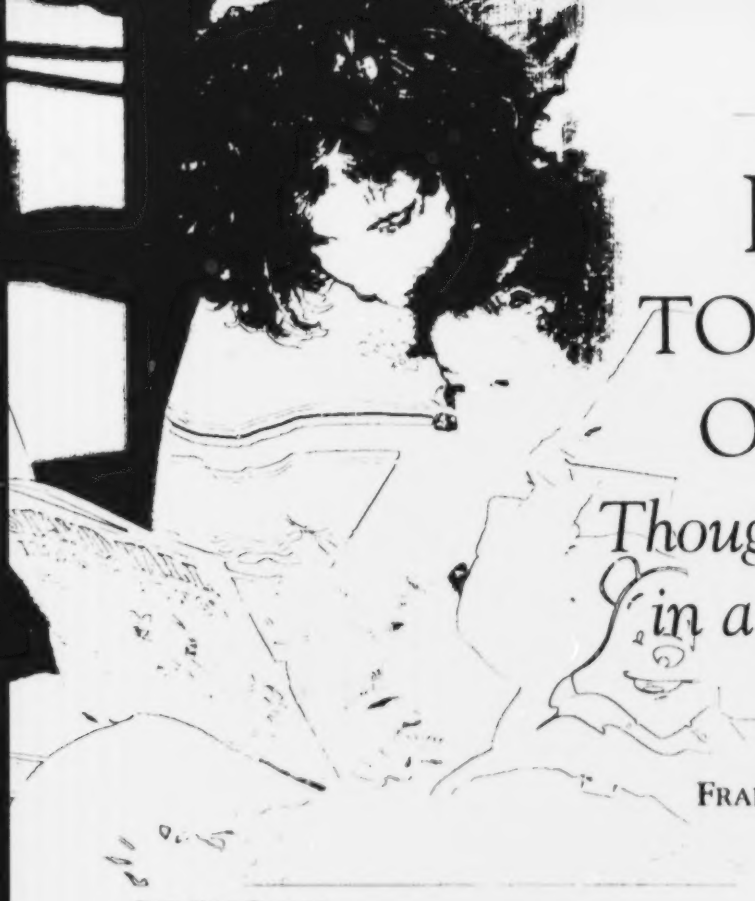

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Listening to the Voices of Families:

Thoughts, Hopes, and Fears in a Latino Community

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In providing early childhood services to children and families, we too often by-pass parents; that is, we fail to make a deliberate effort to understand their child-rearing goals and priorities and to consider the implications of these goals and priorities for our own work. Staff may assume that parents agree with their aims, or may recognize that in some instances they probably do not, but remain unsure what to do about it. Having worked—or even lived—in a particular community for years, program staff may think they know and understand the parents of the children they served. In reality, despite the staff's desire to work with parents respectfully and as collaborators, there is often a gap in understanding between program staff and parents.

The problem of not adequately understanding parents' child-rearing goals and priorities and the resulting need to actively learn about them are important to programs serving children from immigrant and refugee families. Parents in such families may be struggling to reconcile conflicting cultural beliefs about children and their developmental needs, wanting to keep their children attached to family and community traditions, yet also wanting them to succeed in the larger world.

What, then, ought providers know about families' beliefs, priorities, and preoccupations, and their expectations of early childhood programs? What ought they do with and about such knowledge? How can staff be helped to challenge their assumptions? How can staff be provided with opportunities to examine the complexity and the sometimes conflicting values that underlie their relationships with parents? How can they be helped to develop an understanding of how one's own history, experience, and cultural background may influence one's work with children, families, and colleagues?

In this article we describe an approach to helping program staff gain a better understanding of the families they serve. This approach draws from a systematic process of

at a glance

- In early childhood services, staff may not adequately understand parents' child-rearing goals and priorities.
- Structured focus groups with parents can form a collective narrative of their thoughts, hopes, and fears.
- The Caregiving Consensus Model gives program staff more insight and helps them recognize the need to integrate parents' perspectives with their own.

inquiry first developed by Gilkerson and Stott (1997) called Caregiving Consensus Groups. It involves a series of in-depth focus groups with program family members, each guided by a specific set of questions, but structured to build a kind of collective narrative of their thoughts, hopes, and fears. The very act of talking with parents in a systematic way about their own beliefs and concerns (with a staff member present as a co-leader), taping the discussions and transcribing them, and presenting staff with direct quotations, has the potential of reaching staff in a powerful way.

The present study was conducted as a collaboration between Project Hope, a community-based agency, and Erikson Institute, an academic institution. Project Hope is a two-generation program that provides center-based parenting support and early childhood programs for children from ages birth to 5 years and their families. Erikson Institute has specialized in graduate education in child development and early childhood education for over 35 years. Because Erikson's focus is on educating practitioners from diverse backgrounds, the faculty is continually faced with questions regarding the relevance of child development theory to the students' life experiences and frontline practice. We welcome the opportunity to collaborate with a community agency to investigate family views and program practices as a way of informing our teaching and scholarship.

For the 7 Mexican and Mexican-American mothers in our study, adapting to the host or dominant culture was the greatest source of stress.

The 7 mothers participating in this study were Mexican (born and grew up in Mexico) or Mexican-American (grew up in the United States) and had children enrolled in the preschool program at Project Hope, which is in Little Village, a Latino community on Chicago's near south side. A total of five focus groups were held over a period of 4 months. The discussions took place in Spanish, with a staff member who also translated, although the second author (Halpern) speaks Spanish and interacted directly with the mothers at a number of points.

The program staff and we were particularly interested in the mothers' thoughts about preschool education, school readiness, and their children's forthcoming transition to school. We were also interested in broader issues of families' child-rearing values, goals, and priorities; sources of support and stress around child rearing; and, because a number of the mothers had grown up in Mexico, mothers' experience of adjusting to life in the United States. Although we began each focus group with a specific set of questions, we adjusted subsequent questions based on what mothers actually talked about. At the last meeting, we shared with mothers what we thought we had learned, providing one additional opportunity to strengthen our understanding. The final steps in the Caregiving Consensus Group process involved organizing the data into themes and sharing findings with program staff. For a description of our procedures and methods, see Gilkerson and Stott (1997). The following themes are presented in a form very similar to that presented to program staff.

Stresses and Supports

- The process of acculturation was itself a central source of stress.

The greatest source of stress for this group of mothers was the process of adapting to the host or dominant culture. Maintaining cultural values and practices under the pressure of new expectations for parenting in the tradition of the Euro-American culture was very difficult.

"It's harder with us Latinos because we're a different culture."

"It's hard to maintain your own family's culture. It's harder to learn another one."

It was difficult to both assimilate and to maintain one's family's culture. Mothers felt they were engaged in a kind of balancing act.

A related source of stress concerned preparing children to deal with discrimination and the marginal social position of their families.

Raising children in the United States was perceived as more difficult than doing so in Mexico.

- Family relationships were sources of both stress and support.

Some mothers complained that their husbands or mates were passive or absent in assisting with child rearing and were not good role models.

"I wish there were more things my husband would teach our son."

"The fathers don't do anything. I would like my husband to teach him things."

"My kids never had a father."

Some mothers, on the other hand, cited their children's fathers as supportive.

"I've been talking to my husband and I want to go back to high school."

"My husband's already starting to save money for education for the kids."

- Mothers saw danger everywhere.

The mothers saw dangers in their neighbors and sometimes in family members.

"The people around here—you don't know what they're going to do to them [the children]."

"I see danger coming from everywhere."

They also saw danger in losing their ethnic identity and cultural traditions and feared outside influences.

"I learned to see the future—that there's more danger for my children."

"I have to keep fighting against what he is learning outside the home. I have to keep after him constantly so that he'll maintain respect for adults."

"It's hard because they get ideas from friends."

These mothers expressed a sense of powerlessness, and had a perception that they have limited ability to protect their children in the long-term. They worried in the short-term that someone would harm their children. They were worried in the long-term that their boys would join gangs and their girls would get pregnant.

"I'm trying for my kids. Now when they're small, I feel I can do a lot for them. When they're 10 I don't feel I can do anything for them."

- Support was seen in Mexico—as a base to return to themselves, or to send children to for their safety.

This connection to Mexico seemed to be both a way of dealing with acculturation as well as with living in a dangerous environment.

"If I can't make it here I will go back . . ."

"My aunt saw those signs [towards gang-like mentality and behavior] in my cousin and sent him back to Mexico with my grandparents to work in the fields. Now he's 21, he's back, he's married, he's working, and he's doing everything right."

Child-Rearing Goals and Strategies

- Interdependence — collectivity, family unity, and responsibility to others — was a central child-rearing goal.

Being an active family member and maintaining close ties were important values. But there were competing values. While family and interdependence were important, there was some recognition for the American value of independence—and so as suggested above. The mothers also equate family with responsibility—which includes family loyalty and protection.

"Stay involved in their lives, because if you don't, they'll go looking for something in the streets."

- Respect for self and for others was an important goal, but one that became difficult to maintain as children grow older.

Respect for adults and getting along with peers is critically important and emphasized in these mothers' discussions.

"Respect for others and themselves [is the most important thing a mother can teach her child]."

"The most important thing he [child's father] can teach him is how to treat his wife. And how to respect himself."

[A child is ready for school] "when they know how to respect other children."

But the mothers worry that respect may diminish with the child's age—and that they will lose control.

"When they're young they understand more but once they get to be 10 or 11 they're not feeling this thing towards adults anymore."

"When they're 10 they're already making their own decisions when to respect or not. I've noticed that my siblings have always respected me, but sometimes it leaves them and I have to remind them. But they're decisions they're making. I can tell them over and over again to be respectful, but as much as one tells them, they're going to make their own decisions."

The mothers lamented that respect was not valued in American culture.

"In Mexico they are taught that if two adults are talking a child does not interrupt."

Mothers said that the best way to ensure that children remain respectful is to start teaching them early, and to make sure mom is with them.

Mothers felt that they had to fight the messages that the child was getting outside the home and family.

"I have to keep fighting against what he's learning outside the home. I have to keep after him constantly so that he'll maintain respect for adults. It's hard because they get ideas from their friends."

- Mothers experienced tension between protection and overprotection.

The stresses arising because of acculturation and situational forces (and very likely psychological forces as well) were also reflected in the mothers' ambivalence about separation and protection.

"Help them not to be scared. Like I was scared when I first brought them here. I didn't want them to be separated from me. He also gets scared when I leave him. Help them get used to that."

"People have told me before, but I have come to realize it. I'm trying to protect him less, but it's hard."

- Discipline is closely tied to respect and obedience.

Spanking is a traditional form of discipline typically used to gain obedience.

"I threaten him with punishment. I take away toys he really likes. When that doesn't work I tell him 'I'm going to spank you.'"

"I hit them. Now, when they don't listen to me, all I have to do is say, 'Do you want me to get the belt?'"

The mothers drew a clear distinction between discipline (spanking) and abuse.

"I think it's when there are marks on the child or when blood is drawn. But not spanking."

Some mothers describe physical abuse, emotional abuse, and neglect in their families of origin and in their current neighborhood.

"My mom screams at my siblings, 'You're a whore! You're an idiot!' And she doesn't think anything of it. That's abuse."

"There are some kids across the street from me that no one takes care of. There are a lot of people in the house but all day the kids are in the street…She doesn't hit them, but they're never fed and they're always outside at night. That's abuse."

The mothers feel caught between seeing spanking as necessary to gain obedience and the perceived need to be less authoritarian.

"There are times I'm very anxious and I'll end up hitting him if he doesn't understand, but it's really rare."

"When I hit my children, I talk to them and explain to them why I did it. I don't let him just go off and cry. I go and try to comfort them. I try to make it so that they don't stay with that bad feeling."

"[I'm trying to be] very different. I'm trying to do her good as opposed to doing her harm."

Mothers noted that they lacked patience themselves, and yelling was common, often when the mothers' patience ran out.

Language and Schooling

- The need for bilingualism posed a variety of challenges for mothers.

Mothers wanted their children to speak both languages and recognize English as the public language of schools and jobs.

They also were ambivalent about their children learning to speak English – those who did not know how to speak English themselves were concerned because they could not understand their children's communications, or were embarrassed that their children corrected them. For the most part, the mothers read to their children in Spanish, but struggle in two languages.

"Spanish, some English. Well I act like I'm reading in English."

"I read to them in Spanish, but if they bring me a book in English, I make up the story in Spanish."

Mothers believed that they should learn English but felt unable to.

- Mothers were ambivalent about preschool.

Mothers recognized some of the commonly stated purposes for preschool.

"It's better to start them early. My mother started my sister at 3 years old and no other child started that early and now she's the most intelligent young woman."

"When they come to preschool, they start getting accustomed to different learning styles. They start sharing the attention. They know the activities that will be in the classroom."

Yet for some—or even for many— children, beginning preschool later was better, because children were going to be in school for many years and would get bored.

"I've heard a lot of people say, 'They're too small to be in school. They're going to have to be in school for so long.'"

"I told my friends that I'm going to put my child in Head Start and they all tell me, 'No, he'll get bored, and he's not going to want to go to school.'"

Preschool was not perceived as connected to school, for example, in helping children get ready for school or learn how to be students.

- Mothers' views of readiness for school focused primarily on psychological and social issues.

Mothers believed that, in general, it was difficult (for preschool programs or parents) to prepare children for school.

"I don't think anyone's ever ready for school, because kids are different, teachers are different."

They would know children were ready for school when the children were "interested."

"[He will be ready for school] when he is starting to be interested in learning, and when he shows interest in school."

Preparing children for school meant letting go.

- Mothers had a variety of fears about their children's forthcoming school experiences.

They were afraid teachers would not pay attention to their children; that their children would not be able to fend for themselves.

"C will not always have someone to hug him . . ."

- Mothers felt powerless to shape their children's success in school.

Although they wanted their children to do well in school, they lacked a sense of efficacy about their ability to influence their children's school careers. They did not know what to do or say to keep children committed to school.

"There are times when parents who don't have an education don't know what to do when a child tells them they no longer want to go to school."

Whether children stayed committed to school or even went to school at all was perceived to be up to them.

"We just have to wait to see what the kids want. What if they don't want to study?"

"There are some kids who don't want to study or work. They just want to be taken care of at home, or be out on the street. I don't like that."

- Success in school is seen as related to, but not the key, to success in life.

Other goals—for example respectful behavior toward elders—were just as important.

"It doesn't mean that if you have an education you're going to have everything...What good is education if you don't have respect?"

Early work is seen as a legitimate alternative for children not interested in pursuing education.

- Mothers' ambivalence about school stemmed in part from their own negative experiences with school.

A few mothers had memories of being treated harshly.

"We weren't treated very well. I used to get hit with a ruler."

A number of mothers had dropped out at the end of elementary or middle school.

"I didn't like school, but now I regret I left."

"Both my parents wanted me to study, I just didn't want to."

In some cases, but by no means all, mothers' own parents did not support their efforts to stay in school.

"In my house we never talked about education."

"My mom never talks about education. She works, she goes to Mexico and she comes back."

"My father said, 'You're women. You're going to get married. What future do you have?'"

The Role of Project Hope

- Mothers viewed Project Hope as a safe haven.

When asked about what Project Hope meant to them, mothers indicated that they were comforted by the existence of the program. They believe both children and mothers are treated well.

"It's hard to find a place like this. I was taking my children somewhere else. They didn't get much from that program. A place like this is better."

- Mothers thought that the program fosters learning in children.

"I like the attention they give to the individual child. Whatever each individual child needs, they receive it."

- Mothers saw the program as offering support for themselves.

"This program has helped me. I used to yell at my children. But this program has helped me to listen and see how the kids act."

- Relationships were seen as critically important.

Not surprisingly, relationships were seen as key to what the program meant to the mothers. They greatly appreciated the focus of the program staff on forming relationships with parents and children—partially perhaps because it fits in well with their culture's focus on interdependence as including giving and receiving support. Furthermore, interacting with others and forming relationships superceded other goals for their children. As important a goal as being bilingual is, the mothers think that it's more important for the teacher to have a good relationship with their child than to be able to speak Spanish to them.

Program mothers see relationships as key. Although being bilingual is valued, the mothers think that it is more important for a teacher to have a good relationship with their child than to be able to speak Spanish to them.

"This program has helped me to listen and see how the kids act. And I start seeing that I'm provoking him to act a certain way by my behavior."

Caregiving Consensus Groups: Reflections on the Process

The purpose of a program-based inquiry like the Caregiving Consensus Model is to give a program greater insight into the thoughts of the families it serves. We think of it as a way of listening to and codifying the voices of families in a form that is accessible to all program staff. The direct and powerful voices of these mothers gave some staff members (especially those who were not Latina themselves) a new way of looking at the values and child-rearing practices that these mothers hold sacred. This new understanding of the mothers' priorities and goals helped these staff consider their own assumptions and the implications for their work. A majority of the staff are Mexican or Mexican-American. They found many of the themes familiar and consistent with their understanding of the families. However, the findings also raised issues that staff either had not been aware of, or that, though they were cognizant of them, they had not dealt with in their work. For instance, debate was sparked on several issues.

Staff had already begun to struggle to respond to issues of *bilingualism* and *parental literacy*, both as they affected parents' own integration into American society and as the affected parents' ability to help prepare their children for school. The Consensus Group findings highlighted for them the threat to parent-child relationships embedded in the language gap between some mothers and their children.

The Consensus Group results concerning *fathers' roles* in their families — both positive and negative — were an issue staff had not been aware of, and stimulated discussion of how the program could more actively support fathers in their role in the family. They spoke of the long, hard hours of work the fathers perform and the financial strain they carry. They also spoke about social and language isolation, and that the fathers might be less apt to talk about their feelings and struggles than the mothers are. They considered having a fathers' group to discuss issues pertaining to men and fathers in this community.

Staff were most surprised that the mothers were not making a connection between what happened at Project Hope and *what children were going to need to be prepared for school* (in spite of the fact that mothers strongly appreciated the work of Project Hope with their children). They discussed the sense of a "cultural barrier" that they felt between themselves and the mothers around the education issue. They felt that they could do more with the mothers, for example to discuss mutual ideas about the role of early childhood education—both for the children's current developmental needs and for future school success. They also felt they could do more to help families with the transitioning process to "the big school," and to help mothers understand the American school system better.

Perhaps the most important benefit of the process of listening to the voices of families in this way was to give the staff a slightly different focus for their staff meetings and reflections. As respectful as the staff was to the mothers' indigenous forms of socialization, through this process they sought to make their program even more culturally convergent. In many ways the staff continued to develop what Isaura Barerra refers to as Skilled Dialogue (this issue, p. 8). That is, the process helped them to acknowledge specifically the range and validity of diverse perspectives and to see the need for more collaboration with both mothers and fathers in order to integrate parents' perspectives with their own.

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Making New Choices Possible:

Understanding Differences in Infant Feeding Practices Between Latina Mothers and Anglo Health Care Providers

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By the time they are mothers, most women have ideas about what babies should eat and what a healthy baby looks like. After all, they have seen babies in their extended family throughout their growing-up years, and have observed the ways mothers, babies, and families interact to promote certain child feeding behaviors and growth patterns. They also observe which mothering behaviors are rewarded and which are unfavorably evaluated in their family and in their neighborhood. And by observing the social shaping of mothering behavior, young women are enculturated to perpetuate accepted cultural behaviors in motherhood—or face unpleasant judgments.

For Latinas of Mexican descent living in the western United States, cultural feeding beliefs have their roots in a shared history. For example, many Latinas have a preference for a chubby baby. Not surprisingly, mothers who prefer a chubby baby often have a chubby baby (Alexander, Sherman, & Clark, 1991). Why do mothers—particularly Latinas—prefer heavier children? A physically hearty and stout child—one who is *robusto*—is preferred in cultures where high levels of infant mortality prevail and where frail, thin children are observed to fare worse than their stockier counterparts. For families of Mexican descent, an historical memory of food scarcity and high rates of infant mortality may explain the cultural preference for chubby babies that lingers even in a time of plentiful food and low infant mortality.

Health care providers—including nurses, physicians, nutritionists, Women, Infants, and Children (WIC) workers, and others—also share a basic template for what constitutes a healthy baby. Health care providers' beliefs are ingrained through professional education that instills in us a respect for child feeding guidelines based on the current

at a glance

- By the time they are mothers, most women have been enculturated with beliefs about what a healthy baby looks like.
- Many Latinas, coming from a culture where thin children do not survive, prefer chubby babies.
- In the U.S., professional health care providers have been trained to be concerned about childhood obesity.
- Talking about changes in feeding recommendations can foster an exchange of ideas and make new choices possible.

state of scientific knowledge and an expectation for children to track along typical growth patterns. Clinicians and researchers rely on growth charts developed by the National Center for Health Statistics using National Health and Nutrition Examination Survey (NHANES) data (Centers for Disease Control and Prevention) to help form a clinical impression of the adequacy of a child's growth. Taken-for-granted knowledge about growth and child feeding is the cultural dimension of child feeding. If a parent and a health care provider have different images of a "healthy child," and if each suspects the other of not following "common sense" in child feeding, both parties may wonder, "Don't they know better?"

As health care professionals we may not know how to assess or respond to the taken-for-granted cultural beliefs that shape parents' understanding of "healthy" foods for babies and their expectations about how "normal" babies grow.

Cultural preferences, expectations, and beliefs held by parents and communities may contribute to the alarming increase in childhood obesity nationwide. Health experts, including the U.S. Surgeon General, warn the public that childhood obesity is associated with immediate and long-term physical and mental-health problems (U.S. DHHS, 2000 [Objectives 19-3c, 19-2]; 2001). The lay public is also becoming more aware of—and more concerned about—obesity in childhood, as evidenced by recent journalistic attention (Brownlee, 2002; Cowley, 2000; Critser, 2000). Conservative estimates place the population prevalence of childhood obesity at 10–25% (Dietz & Gortmaker, 2001; Troiano & Flegel, 1998), a documented increase of 100% in the study interval between NHANES II and III (1980–1994). For ethnic minorities, the childhood obesity problem is even more pronounced. A tri-ethnic population study in Texas found national (NHANES I) data grossly underestimated rates of overweight/obesity among Latino children. The researchers observed overweight prevalence rates of 40–50% for school-aged Mexican American boys and 34–52% for school-aged Mexican American girls (Park, Menard, & Schoolfield, 2001). High rates of childhood obesity affect the long-term health potential of children, because childhood obesity tracks into adulthood—the older the obese child, the greater the chance he or she will become an obese adult (Guo, Roche, Chumlea, Gardner, & Siervogel, 1994; Whitaker, 1997). Infancy is an oft-neglected, yet key, developmental time period for the establishment of healthy eating patterns and the prevention of obesity and concomitant health problems. Changing feeding practices that predispose children to the risk of overweight is difficult for a variety of reasons. As health care professionals we may not know how to assess or respond to the taken-for-granted cultural beliefs that shape parents' understanding of "healthy" foods for babies and their expectations about how "normal" babies grow. The first step in prevention of childhood obesity is to work with Latino families to identify common but potentially obesigenic feeding practices and the cultural beliefs that perpetuate them. The next step is to collaboratively identify ways to change feeding behaviors to be more healthful.

Learning About Latino Infant Feeding Practices

To learn more about Latino child health behaviors and the day-to-day ways that families feed and care for their young children, I conducted a 5-year study in Denver, Colorado. The population of Hispanics in Denver was approximately 450,000 at that time. The families included in the study were selected by convenience from several local prenatal clinics and they met study criteria (mothers were all Latina, not first-time mothers, not teen mothers, and pregnant at time of recruitment). All of the mothers were willing to be involved in a longitudinal child health study, and they all spoke English, Spanish, or both languages. With the help of two research assistants, I obtained informed consent from each mother (and many fathers) for their study participation using a consent process approved by the Colorado Multiple Institutional Review Board. Then a series of observations, interviews, photographs, and medical records reviews began. I interviewed the 28 study mothers in their homes repeatedly, beginning in pregnancy and continuing until their child reached 19 months of age. I collected a total of 257 interviews, or nearly 10 interviews per mother. Mothers completed acculturation measures and demographic information profiles periodically throughout the study. I supplemented maternal interview data with traditional ethnographic participant observation, writing fieldnotes about my observations. I also collected children's anthropometric measures at each home visit, children's well-child and ill-child medical records, and focus group data from a series of discussions held with fathers, grandmothers, peers of mothers, and health care professionals about infant health practices. Photography was another important part of the study. Mothers took 1,018 photographs with disposable cameras, the researchers took 943 photographs, and a special Day in the Life of a Child project with three families produced another 1,234 photographs. All of this data—from interviews, medical records, observations, anthropometric measures, and photographs—tells us about how Mexican-descent Latino children in northwest Denver are fed, how they grow, and how their parents talk about the children's feeding and nutrition. By combining this data with other research studies, we can identify shared cultural feeding practices for infants in Latino families.

PHOTO: NANCY GUADAGNO

Bottle-Feeding, Cravings, and Infant Preferences

From my earlier work as a public health nurse in the Latino community, I knew that bottle-feeding for an extended period of time was a common practice in the community where I was working. After beginning this study and analyzing the Day in the Life photographs I began to fully realize the ubiquity of the bottle in children's lives (Clark & Zimmer, 2001). The three children involved in the Day in the Life project were all over 15 months old by the time they were photographed. Each child was photographed with one or more bottles of milk, some given at naptime. There are photographs of a bottle dangling from a child's mouth as she watched television, a bottle dripping onto the carpet as the child used it to "paint," and bottles being prepared by mothers and grandmothers for children to drink from throughout the day and night.

Other study families explained in interviews that even young infants were given flavored milk in their bottles; chocolate and strawberry flavors were most popular. Other milk additives that mothers used were maizena, a corn-based thickener; rice cereal; and raw eggs. Sometimes mothers used carbonated drinks, Kool-Aid, and juice in place of milk in bottle-feedings. Teas were bottle-fed to babies for their health benefits, with *manzanilla* (chamomile) and yerba buena (peppermint) the most common choices. Why so many bottles? As one mother of a 16-month-old boy explained,

> *I was gonna take [the bottle] away now that he turned 1 [year old], but my husband told me no, you know, to keep giving it to him for a while. [He] just [has] fresh milk [in the bottle]. Or else I'll put in like a teaspoon of Quik, or else sometimes I'll give him Kool-Aid, pop…I'll shake it up real good and get all the…what is it? The acid or the gas out? He's good at drinking pop. He is. He likes pop in the can. He doesn't really like water. I'll put a, spoon of sugar to make it sweet and he'll drink it like that 'cause he tastes the sweetness.*

Mothers often described giving a baby "what he liked." Babies' preferences were best fulfilled, they thought. In many respects, this cultural understanding of satisfying infants' food preferences or cravings is similar to the cultural reasoning about satisfying pregnant women's food cravings. As one young pregnant Mexican woman explained,

> *[My grandmother] was telling me about cravings. She was making me eat half of her banana because she was eating a banana and she has this thing that if I even look at it, the baby might have wanted some and I better give him some. You know, so its umbilical cord [doesn't get tied up]… But I didn't want any banana! Oh, she made me. [Finally, I said,] "Okay, I'll take some of your banana."*

Indulging cravings and preferences of pregnant women and babies is a tradition with health consequences among the Latino families I worked with. We can help parents to acknowledge their children's preferences for certain foods and feeding methods while also setting limits about food.

From the practitioner's point of view, preventing childhood overweight may depend on helping parents and families to eliminate unnecessary, high-calorie infant food and beverages and successfully transitioning children from the bottle to

the cup. Items like candy, high-calorie milk flavorings, more than 6 ounces of juice per day, and non-nutritive carbonated drinks and Kool-Aid were common, unnecessary, and difficult to curtail. Mothers are not isolated decision-makers in most families, and certainly not in typical Latino families (Clark, 2001). Fathers have opinions, too, as do grandmothers and babysitters. Letting the baby "keep his bottle a while longer" was seen by parents as a demonstration of their affection and respect for an infant's preferences. Sometimes sneaking the baby "treats" was a way family members showed their affection, even if it meant sabotaging a parent's plan for infant feeding. As one mother of a 7-month-old explained,

> *[I don't, but] everyone else does give him candy. It just pisses me off. I'm like, "Don't give him candy!" His aunts, cousins, everybody. They give him chocolate, suckers, stuff that could rot his teeth. He was sitting on his auntie's lap and he was all happy and I was wondering why he was so quiet. Well, she was breaking up these little Reese's candies to feed him!*

Just as family members hold beliefs about indulging infant food preferences, health care professionals also share ideas about infant-directed nutrition. On-demand breast-feeding is one example of a shared professional belief about what is best for babies. Another example is the emerging professional idea that infant development can open up windows of opportunity for introducing new foods. Roberts and Heyman (2000) suggest that a "window of opportunity" exists for children from 12 to 21 months, and that infant-directed exploration of food can be encouraged at that time. Even if a child adores his bottle and wants it during the day and at bedtime, bottle-feeding is currently discouraged by physicians and nurses for older children. The consequences of prolonged bottle-feeding may include dental caries, increased likelihood of inner ear infections as a result of stagnant milk pooling and providing a growth medium for bacteria, the potential for calorie excesses (or inadequacies) from a diet based predominantly on liquids, and the difficulty of attaining age-appropriate Daily Reference Intakes (DRIs) of nutrients like iron and zinc with a principally milk-based diet (Serwint, Mungo, Negrete, Duggan, & Korsch, 1993; Bruerd & Jones, 1996; Elli & Atkinson, 1996). Generally, professionals advise weaning from the bottle sometime between 12 and 15 months of age (Frazier, Countie, & Elerian, 1998) to avoid these problems. Weaning from the breast is not discussed as much by professionals, and I could find no recommendations about when breast-feeding should be terminated. Because most mothers have difficulty sustaining breast-feeding past the first few months, breast-feeding termination is far from being a clinical problem of significance. Juice is not recommended for bottle-feeding, and is never recommended as a supplement for children less than 6 months old (American Academy of Pediatrics, 2001). It would be interesting to track how these changes in professional beliefs change and in response to what kinds of data and waves of public opinion. But the point here is to remind us all that professional culture has a list of taken-for-granted ideals in child feeding unique to the professional culture, and those ideals differ substantially from the beliefs in some Latino families.

Introduction of Complementary Foods

Although mothers we spoke to knew that doctors recommended introduction of complementary foods at 4–6 months, there was divergence between knowledge of the recommendations and implementation of them. As one young mother explained, Mexicans had different ideas than American doctors about healthy feeding. She explained, "A lot of doctors say when a child is at a certain month they can start eating. But Mexican people just feed their babies. Everything. That's how come they are healthy. 'Cause they eat more."

Another mother's rationale was similar: "We do against what the doctors say, like with her, the doctor said don't feed her until she's 6 months. I started feeding her at a month old." Even Conchita, who initially planned to introduce complementary foods at 6 months, reported that her 4-month-old baby was eating infant cereal, bananas, potato, and little "bites" or "tastes" (*probaditas*, in Spanish) of beans, tortillas, and other foods prepared for family meals. The early introduction of complementary foods, the variety, and amounts given were typical of Latinas in the study.

Prepared commercial baby foods were a staple for new immigrant mothers, who were pleased at the convenience and safety of the bottled baby foods. Nearly every mother referred to baby food as "Gerbers" and many had brand loyalty, despite the cost differential. As one low-income Spanish-speaking mother said, "It costs 40 cents for a small bottle, and 50 cents for a larger one. That's a lot of money." But because "Gerber" was considered food fit for a baby, mothers paid the price. The "Gerber" phenomenon crossed languages and levels of acculturation. A search of the interviews showed that mothers in our study were aware of other brands, but preferred the Gerber brand.

When babies became toddlers, they began on their second round of brand-name foods. McDonalds was a highlight in nearly every home with a toddler. One Spanish-speaking family even reported that their 16-month old could recognize a McDonald's sign from his car seat and signal to the family his excitement. Without prompting, at least 6 of the 28 families mentioned McDonalds by name as part of their baby's eating experience, and several listed Happy Meals or french fries as their child's favorite food by 16 or 19 months of age. The preference for fast-food and french fries likely reflects families' eating patterns and their children's preferences for familiar foods that are also preferred by other family members. Americans of all age groups and ethnicities are described as eating a growing number of meals from away from home in fast-food environments (Schlosser, 2001), accounting for the

fact that the favorite vegetable listed by U.S. children was the french fry (Franklin, Dashti, & Franklin, 1998).

The introduction of complementary foods among these Latino families was early, typically 1 or 2 months earlier than the recommended 4–6 months. *Probaditas* and commercial baby foods co-existed for a period of time, with some families quickly switching to table food and others maintaining a baby food routine for several months. Before their first birthday, children were exposed to fast foods. One of the photographs we took visually emphasized the overlap of traditional Mexican feeding patterns with more American ways of feeding children. In the photograph, a very traditional homemade *sopa de pollo*, or chicken soup, was placed in the middle of the table. Rice and chicken pieces—with bones in—bobbed in the serving bowl, as several cans of Mountain Dew sat adjacent to the soup on the table. The 15-month-old was offered both the caffeinated, carbonated soda and the traditional soup, illustrating what Popkin (1994) would call the "nutrition transition" made by immigrant families. The nutrition transition reminds us that families worldwide are replacing traditional whole grain, low-calorie foods with processed high-calorie and high-fat foods. For families in the midst of acculturating to American foodways, creative mixtures of traditional Mexican dishes and typically American fare were served side by side.

Selecting traditional foods for babies like beans and soups signals an identification with tradition and ethnic heritage, whereas choosing to feed brand-name baby foods communicates that one is a modern mother with enough money to buy these kinds of prepared meals.

Discussing Feeding Choices, Finding Common Ground

Mothers in our study expressed their "Mexican-ness" in their feeding choices. "We Mexicans give our babies these kind of teas," said one mother, "It's so many things that we feed the babies, when they are baby-babies." Bottle-feeding practices, timing of the introduction of complementary foods, and the type and amount of food given to infants are specific practices that reflect underlying cultural beliefs, such as the importance of responding to infants' food preferences, a belief that even young children can make dietary choices, and the conviction that babies require solid foods to be satisfied and physically robust. Besides being a cultural practice, infant feeding choices are also symbolic. Selecting traditional foods for babies like beans and soups signals an identification with tradition and ethnic heritage, whereas choosing to feed brand-name baby foods communicates that one is a modern mother with enough money to buy these kinds of prepared meals.

In every Latino household I visited, traditional cultural beliefs about appropriate infant feeding mixed with the advice of professionals, popular culture, time and money constraints, and marketing programs to result in unique parental feeding choices. Eclectic feeding practices reflected the wide variety of foods available to families and the multiplicity of ideas about appropriate infant feeding. From prior research, we know that professionals are at a disadvantage in this cacophony. Many Latinos have had unpleasant experiences with health care providers, lack confidence in them, and have negative attitudes about them (Anderson, Giachello, & Aday, 1986; Clark, 2002; Flores & Vega, 1998). If this is so, how do we as professionals share our cultural ideals about infant feeding and motivate families to adopt those practices and discontinue others?

In the course of conducting my research, I was often asked for my professional opinion about infant feeding choices and nutrition. I was not there to educate or change families, so this solicitation of my opinion was uncomfortable for me. I was initially hesitant to intervene with families, and felt far more at ease discussing and observing their unmodified child-rearing patterns. But mothers' inquiries caused me to re-evaluate my role and the practices I was studying. By simply asking for my opinion, mothers were demonstrating their openness to other ways of doing things and a willingness to consider changing their current practices. They were also showing trust in me as a nurse and perhaps as a mother. This interest in hearing my opinion demonstrated the cultural value of *respeto*, or deferential behavior toward me as a professional. My ongoing relationship with study families over nearly 2 years also built a relationship of *personalismo* (professional friendliness) and *confianza* (trust; National Alliance for Hispanic Health, 2001). On several occasions, I did share my professional beliefs in an informational tone, realizing that I was asking for far more disclosure from these mothers than I was giving in return. This was one way I could adjust that balance and provide some reciprocity by sharing my own cultural beliefs about child feeding.

In my role as a public health nurse, I work with families in a more directive way. I have found it easiest to review what I have heard from other Latino parents about child feeding before I begin a conversation about a particular child and family. In a non-judgmental way, I mention to parents that I am aware of the range of infant feeding choices in Latino families. Some parents use traditional teas and *manzena* in bottles, some begin tastes of table food early in life, and others buy baby food. My rationale for starting with a review of what I know is to demonstrate my awareness of the latitude and flexibility of community values and practices, and my openness to variation. I then ask the mother or parents to describe their current infant feeding practices and what they expect they will do over the next few months. Sometimes I probe specifically for bottle propping and the

use of flavored milks, or explore more fully the amount of table food being fed to an infant. I try to ask about family input and dynamics around feeding. When I encounter practices that could be modified for better infant outcomes, I usually start by explaining to parents that we used to recommend certain feeding practices years ago, but that new information in the last few decades has modified our ideas about what is best. For example, if the family is using evaporated milk in the baby's bottle, I explain that many families were told to do this by their doctors years ago, but we have learned that it is not the best choice. Modern advice has changed about evaporated milk as a suitable baby formula. By acknowledging that many infant feeding recommendations have changed, providers avoid inadvertently belittling family members who still cling to those ideas by making them merely outdated rather than silly or bad. Describing the scientific rationale underlying recommended feeding practices initiates a discussion with parents about allergens, gut absorption, oral motor development, and general child readiness for advances in feeding. When done in a friendly, conversational, and personal tone, discussions with parents about child feeding build trust and foster an exchange of ideas critical for informed parental decision-making. Finding the common ground shared by parents and professionals is easy, because everyone wants a healthy, robust child. The art to providing care is exploring the practical, symbolic, historical, and cultural differences between us in a way that heightens understanding and makes new choices possible.

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The author thanks Lorena Zimmer, M.A., for her contributions to data collection and analysis, and for sharing her insights about feeding and nutrition among the families in this study. Thanks are also due to Maria Luisa Urdaneta, for her thoughtful conversations about the cultural nature of Latino infant body preferences and feeding practices.

PHOTO: GRACIELA RIOS MUÑOZ

A RELATIONAL AND SOCIOCULTURAL APPROACH

in Services to a Mexican Family Across Three Generations

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I am a licensed clinical social worker and the child of Mexican immigrants. I provide home-based early intervention services to babies who were born medically fragile and who have been discharged from neonatal intensive care units; the babies are at both biological and social risk for developmental delay. My identity and life experiences have informed my understanding of my work with the Latino immigrant community. In this article, I hope to further the understanding of some of the issues facing the Latino community and provide practitioners with ideas on how to address them. Practitioners in all parts of the country now serve Latino families. In the last decade alone, the Latino population in the United States has grown by 60%, and Latinos now represent 13% of the total U.S. population. Of children under age 5, 17% are Latino (National Council of La Raza, 2001).

This article tells the story of my work with one Mexican family—a three-generational household that included Jennifer, a premature infant who weighed 2 pounds, 8 ounces at birth; Patricia, her teen mother; and Elena, the maternal grandmother. I used a sociocultural and relational perspective to address clinical concerns in my work with this family. This approach embraces the complexity of the social and cultural factors that shaped this family's experiences, while using my

at a glance

- Practitioners in all parts of the U.S. now serve Latino families.
- Work with a three-generational Mexican household illustrates a sociocultural and a relational perspective used by the author, herself a child of Mexican immigrants.
- *Personalismo* is a Latino culture value prescribing warmth, individual attention, some informality, an openness in human interactions; it characterizes a Latino relational approach.

relationship with the family members as a vehicle for the work. By describing the work in three stages, I hope to show the progression of trust with the family, along with a deepening of the levels of intervention. Issues explored include a complicated and persistent problem with Jennifer's weight that defied traditional medical intervention, and the impact of differences in levels of acculturation, intergenerational conflict, and the teen mother's developmental tasks of separation and individuation in the context of her education.

Stage One: Working With the Family's Priorities — Patricia's Education

Within a few days of Jennifer's discharge from the hospital, I began home-based early intervention services. During home visits, Patricia began to tell me about herself. She was American-born, but maintained a strong cultural identification with her Mexican heritage. She spoke Spanish in her home to her mother and visited Mexico frequently. Prior to her pregnancy, Patricia had engaged in many high-risk behaviors, including alcohol use, violence with other teenage girls, late hours, and irregular attendance at school. I noticed a framed picture of Patricia with her "homegirls," wearing gang colors, on display in the bedroom that Patricia and Jennifer shared with Elena. There were also several religious icons and a CD collection that was a mix of contemporary American gangster rap and Mexican music. These items represented the multiple influences in Patricia's quest for identity. In spite of Mexican cultural traditions that value family, respect, and proper behavior, it was clear that prior to her pregnancy, Patricia had been headed toward a life in the streets that many marginalized inner-city youth pursue by default. Despite the many universities and places of cultural and natural beauty in the area surrounding her home, Patricia's life was confined to a neighborhood characterized by high rates of unemployment, drug use, and violence, along with deteriorating houses, inferior schools, and numerous liquor stores.

Sometimes sneaking the baby "treats" was a way family members showed their affection, even if it meant sabotaging a parent's plan for infant feeding.

Soon after Jennifer's birth, Patricia discontinued her relationship with Jennifer's father because he was too much a part of the streets and being with him could return her to a risky lifestyle. However, she still struggles to sort out her ambivalent feelings about him. He has not formed a consistent relationship with Jennifer.

Elena's worries

In the initial phase of my work, Elena was always present during my visits. Patricia often deferred to her, especially in conversations about the baby. I know that in traditional Mexican culture, elders and family hierarchies are respected. Hence, although our program focuses on the parent–child relationship, I needed to be flexible and use a carefully tailored three-generation approach in my work with this family. In so doing, I was able to acknowledge and respect the grandmother's place in the family and the importance of her relationship with both her daughter and granddaughter.

I soon learned that Elena was quite concerned about Patricia's past and even her present behavior. Her worries resulted in her attempts to control Patricia's activities through rigid disciplinary practices. These well-meaning attempts to protect her daughter through overprotection strained their communication and began to drive them apart. Without intervention, I feared that the pressure on the mother and grandmother's relationship would result in a serious argument, and Patricia would storm out with the baby, back to her street and gang lifestyle. This kind of disruption could put both Patricia and Jennifer at even greater social risk.

In order to form a working alliance with Jennifer and her mother I had to establish relationships that would facilitate trust and communication. I had to carefully attend to each generation's rules of engagement, which were influenced by their respective places on the continuum of acculturation. I had to understand how, when, and to what degree individual values and behaviors were influenced by traditional Mexican culture, and what was being changed by mainstream American culture.

With the grandmother, a Mexican immigrant, positive engagement included attention to hierarchical roles with particular regard to elders, formal communication, deference, and polite conversation. Through this type of conversation I learned that she had limited formal education and worked two part-time jobs to support her family. The grandmother wanted a better life for her daughter, better than what she had as an unskilled and undocumented immigrant "working like a burro to make ends meet." Her command of the English language was very limited, and she relied on Patricia to be her interpreter and translator in matters involving English. She wanted Patricia to get a good education and to have a career. My initial task was to form an alliance with her, while being careful not to lead her to believe that I was going to collude with her wish to control Patricia.

Careful self-disclosure and awareness of the immigrant experience helped form my relationship with the grandmother. I explained to her that I am the child of immigrants, and I offered my understanding and respect for her sacrifices as an immigrant mother on behalf of her child. I inquired about her migration experience and sympathized with the challenges of adaptation to a different culture. I sensitively spoke to her of her vulnerability as an undocumented worker in the U.S., a status which kept her in constant fear of discovery and deportation. These fears obliged the grandmother to operate in a way that kept her invisible. Thus, even though her daughter is a U.S. citizen, the grandmother's

fears, originating from her own undocumented status, made her reluctant to create waves of any kind. Hence, she accepted my offer to help her advocate for Patricia within the educational system. I also knew that she saw me as a successful Mexican-American woman, and this implicitly tapped into her dreams for a better future for her child.

Patricia's individuation

As an adolescent, Patricia was preoccupied with issues of individuation. I had to be vigilant not to interact with her as another nagging mother figure looking over her shoulder with the answers. I had to support her relationship with her baby while helping her to maintain the vision of her dreams. I regularly admired her baby. I noticed how much the baby looked like Patricia, and pointed out how the baby preferred Patricia to me. I consciously built on the growing affection and attachment that Patricia had for Jennifer. In conversations, I encouraged her to think about her dreams for her baby, past, present, and future, and list things she wanted for Jennifer. Not surprisingly, given her adolescence and her poverty, these were material: nice clothes and toys, a house with a yard, a car. Discussion of Patricia's hopes for her baby set the stage to discuss the connection between her current lifestyle choices and these dreams. I helped Patricia enroll in a high school program for teenage mothers and their babies, and constantly praised her for her efforts. I became an on-site presence at her school and helped her advocate for her needs with school staff. Before meeting me, she had never met a Mexican-American who had graduated from college. Becoming Patricia's role model helped build her confidence. I was living proof that somebody like her could succeed in school and have a career.

In every Latino household I visited, traditional cultural beliefs about appropriate infant feeding mixed with the advice of professionals, popular culture, time and money constraints, and marketing programs to result in unique parental feeding choices.

Stage Two: Failure of a Traditional Medical Approach in Weight Management

In getting to know this family, I learned that the maternal grandfather died from complications related to morbid obesity. Elena, also overweight, had been advised by her physician to lose weight because of medical problems. Although she is healthy, Patricia had been struggling with her weight even before her pregnancy.

Early in the treatment, this family's medical history raised concerns about the potential for weight-related problems for Jennifer. I intervened early, using a preventative medical approach and informing the pediatrician of my concerns. The pediatrician agreed to provide needed nutritional counseling to the family during Jennifer's medical appointments. At these visits with the family, I observed Patricia and Elena's polite, but silent response to the nutritional information. Culturally, I knew that the nodding did not represent agreement and compliance, but rather a respect for the pediatrician's authority and appreciation for her concern.

Despite the pediatrician's ongoing discussions with the family, by the time Jennifer was 1 year old this low birthweight baby had surpassed the 95th percentile on premature growth charts. Additionally, Jennifer was not reaching her gross motor developmental milestones; I suspected that her weight was a factor in this delay. The pediatrician and I agreed that nutritional counseling during well-child checkups was failing to slow Jennifer's rate of weight gain. With the pediatrician's approval, I decided to try what would become my second failed attempt to control Jennifer's weight.

I offered the family home-based consultation from our program nutritionist. The family politely agreed. The nutritionist asked the family to keep feeding records over the course of 3 days. She then computed Jennifer's caloric intake based on the food diary. Everybody became puzzled because the intake presented could not have accounted for Jennifer's level of weight gain. It became obvious that nobody was accounting for the role the extended family members played in Jennifer's food intake. Although the mother and grandmother provided Jennifer with her formal meals, the extended family offered Jennifer many snacks throughout the day as they shared their food with her. As this pattern emerged, I felt prematurely successful. Once we had uncovered the problem, solving it would surely follow. The program nutritionist and I met with Patricia, Elena, and other family members to discuss Jennifer's nutrition. Everyone politely agreed to follow our advice. But Jennifer's weight continued its ever-upward curve.

By now, Jennifer's family nickname had become "gorda" which translates to "chubby." (It is a common practice in Mexican culture to give a person a nickname that describes a characteristic of the person.) Because many Mexicans think of a chubby baby as a healthy baby, I explored Patricia's and Elena's feelings about Jennifer's weight. Both said that they did not want her to be a fat child. They anticipated the future and felt that Jennifer would "suffer" in school by being teased and not being able to keep up with the other children.

At this point I realized that Jennifer's feeding issues were linked to complex family dynamics and would require more than conventional nutritional intervention. It was clear that Jennifer was a much-loved child who ruled the roost. Jennifer had learned that protesting, crying, or tantrums eventually got her what she wanted, particularly from her grandmother. Often what she wanted was a sweet or a soda.

Stage Three: Infant Mental Health and *Personalismo*': A Latino Relational Approach

I decided to take a risk and lead Patricia and her mother somewhere where I wasn't sure they wanted to go. I approached the weight issues head-on and asked Patricia why she thought all our interventions around weight gain had not made a difference. She didn't know. I then told her that I thought the weight issues were more complicated than just food intake. I explained that I felt that limit setting and Patricia's relationship with her own mother were important areas to explore in order to make progress towards Jennifer's weight management. I added that this exploration would have to include Elena. I hoped that the history of our relationship would help me to pursue this intervention. I gave Patricia a few days to think about my offer, understanding that she needed to be the decision-maker. She agreed to explore these issues and she gave me permission to first meet with Elena.

In meeting alone with this grandmother, I tapped into the strength of her love for her family and her hopes for the future for her daughter and granddaughter. I realized I had to offer her something that was relevant and important to her. I talked about improving communication between the generations, because the grandmother had often expressed her frustration and worry about her teen daughter's behavior. For example, Patricia had once again started the worrisome habit of staying out late at night and not coming home. She was again mingling with friends who, in Elena's opinion, were not pursuing healthy lifestyles. Elena worried that Patricia would get off track and that both of their dreams for a successful future would be lost.

It was apparent that the grandmother had successfully been able to pass on her dreams for a better future to her daughter. However, she did not have the necessary skills or resources to help Patricia navigate the institutional and social obstacles that could keep her from realizing those dreams. She resented Patricia any time she felt the teen was not taking advantage of the opportunities that the grandmother had worked hard to provide.

Patricia did want a better future. But, as an adolescent, she lacked the maturity and experience to know how to make dreams into reality. She knew of her mother's dreams and sacrifices, but felt that her mother was too worried about her and didn't trust her judgment. She was unhappy with her mother's constant nagging.

I feared that without proper support, the dreams of both generations would remain unfulfilled.

Because Elena and Patricia were not communicating well together, I used a strategy of meeting with them individually and containing and holding each one's worries and frustrations while always seeking permission to meet with the other and share concerns. This strategy allowed me to better understand their problem and to form the conduit for the beginning of communication between mother and daughter.

The grandmother had successfully been able to pass on her dreams for a better future to her daughter. However, she did not have the skills or resources to help Patricia navigate the institutional and social obstacles that could keep her from realizing her dreams.

I commented to both Patricia and Elena that the style of communication that they shared with each other was likely to be the one they would each use with Jennifer. They each agreed that they were not satisfied with their communication, and wanted something better for Jennifer. I used this common love for Jennifer as motivation for them to commit to the work.

In my conversations with Elena, I inquired about her own childhood experiences, as I suspected that these might be influencing her difficulties in limit setting with both Jennifer and Patricia. The grandmother told me of a childhood of emotional deprivation and physical abuse. She had made great efforts to create a different reality for her children and now her grandchild. She emphatically knew she wanted to spare her family the pain and suffering she experienced as a child, so she intentionally did not use corporal punishment with either generation. She showed her love by indulging them and hardly ever saying no. I admired the grandmother for her success with her children in breaking the cycle of physical and emotional abuse that she had endured as a child. Over several conversations, Elena was able to see that by indulging her children, she was trying to make up for what she didn't get, but had always wanted, as a child. I commented that, given her upbringing, she had never had a chance to learn alternatives to harsh discipline such as positive limit setting, communication skills, or problem solving, and that this made it hard to achieve her wish for well-behaved children. She reported having difficulty dealing with Jennifer's increasing tantrums and disobedience. I made the link to some of her present difficulties controlling Patricia's behavior as well. She quickly made the connection between her own experiences and current difficulties, and agreed to work on these issues in our family sessions with Patricia.

As a result of the family work, communication between the mother and grandmother improved. We were now ready to make the link back to Jennifer's weight. It became evident

'Personalismo' This definition refers to the client–provider relationship. However, the same features are present in all interpersonal interactions. "The ability to relate to consumers in such a way that consumers feel at home and among people who value them, who care about their problems, and who will assist them with finding solutions within their own reality. A Latino cultural value which prescribes warmth, individual attention, and a certain level of informality and openness in human interactions. There is a distinction between bringing personal attention to a mental health treatment exchange and in being overly familiar, which is characterized by this term." (Western Interstate Commission for Higher Education)

that it was painful for grandmother to see Jennifer in distress, so she did whatever necessary to keep her happy. This included giving in to all of Jennifer's food requests, especially for soda, sweets, and nighttime bottles. Although she cognitively understood the nutritional impact of these foods, emotionally she had not been able to set limits with Jennifer without feeling she was being harsh, and without worrying that by setting limits, she might risk losing her granddaughter's love. With her new understanding of the effects of her own traumatic childhood, Elena became able to approach feeding differently.

The use of language has been crucial in the intergenerational work. It was necessary to be able to switch back and forth between Spanish and English. In this way, I kept everyone actively informed and involved while bridging differences in levels of acculturation. For example, although Patricia spoke Spanish to her mother and knew that her mother was not fluent in English, Patricia always spoke to me in English, even in her mother's presence. This left out Elena. I understood that Patricia was working on individuation and that leaving her mother out of the conversation might have been a way to separate. To keep my alliance with Patricia, I had to follow her lead and respond to her in English. I summarized to Elena in Spanish what Patricia had said to me in English, regularly checking in with Patricia to see that I got it right. Even though Patricia understood Spanish, I also summarized the grandmother's responses. Thus, I held each relationship separately while working to improve communication between the generations.

In addition to the teenager's developmental task of separation, Patricia was concurrently adapting to her new role as a mother. As the relationship between mother and grandmother improved, the grandmother's faith in her daughter's future was restored. The grandmother has also gained confidence in her daughter's parenting and, over time, Patricia is becoming the primary decision-maker in matters regarding Jennifer, with close involvement from the grandmother.

Jennifer is receiving developmental infant services both at her child care site and at home. She will soon begin preschool. I reintroduced the nutritionist, and we are currently working more effectively to manage Jennifer's weight. Patricia has graduated from high school and is in her second semester of community college. Greatly affected by Jennifer's experience in the intensive care nursery, she hopes to become a nurse and work with premature babies. Seeing the strength of this family's love for each other and the benefits from the family work they have done, I, too, am hopeful about their dreams for their future.

Conclusion

In this article, I have illustrated the application of a sociocultural and relational approach in clinical practice with a multigenerational immigrant family. In Jennifer's family, as well as in many other Latino immigrant families, the sociocultural context is extremely complex and includes the impact of migration, issues of acculturation, prior family legacies, language, and the effect of marginalization and socioeconomic status on the family's opportunity to create the life they want.

I believe that in order to insure the effectiveness of clinical practice with families, we must use a sociocultural and relational approach in a meaningful way with all families. Furthermore, given the demographic reality of the nation, we must prioritize this multicultural agenda in all areas of early intervention including training, hiring practices, service delivery, research, program design, program evaluation, and policy.

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PHOTO: FLORENCE SHARP

TALK TO YOUR BABY:

Honoring Diversity While Practicing From an Evidence Base

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Decades of child development research inform the work of infant–family practitioners. This evidence-based developmental information is typically an overlay onto our culturally influenced beliefs about how children grow and learn, and onto our own experiences as members of families. Our formation as early childhood practitioners also is strongly influenced by our formal education and the culture of the professional groups to which we belong. The culture of the interdisciplinary infant–family field, for example, values family-centered practices, cultural competence, and honoring diversity. Research, education, and professional identity each influence how we practice our profession.

Early childhood professionals (both degreed and non-degreed) practice in culturally, economically, and educationally diverse communities. Across these communities, both families and professionals are exposed to a variety of points of view as to what is good for babies and what parents should do. Our challenge as practitioners is to value and support culturally adaptive, diverse child-rearing practices while applying evidence-based child development and parenting knowledge to our work with families. Talking with parents about talking to babies offers a good example of an opportunity to view diversity in parenting as a potential source of resilience, rather than as a risk factor or barrier to overcome (García Coll & Magnuson, 2000).

"Talk To Your Baby?"

Over the past several years we have been told that the amount of talk mothers direct to their young children is associated with the children's vocabulary growth and other measures of later success. This research-based information has been translated into a frequently heard slogan, "Talk to Your Baby." This advice, unfortunately, may be an example of the way in which the answers to strictly defined research questions are communicated as generalized recommendations for parents and professionals. Researchers themselves tend to avoid this oversimplification. For example, after reviewing

at a glance

- Infant–family practitioners have a role as mediators between the culture of research and the cultures of families.
- We need to understand our own culture as if we were outsiders to that culture.
- We can join with a parent to better understand each other's communication styles.
- Joining with a parent to speculate on the baby's experience and motivation strengthens our shared understanding of this particular baby.

the evidence-based literature about the connection between parents talking to their children and developmental outcomes, authors of *From Neurons to Neighborhoods* conclude:

> . . . under typical circumstances, parents around the globe *seem intuitively to talk to children in ways that work quite well in fostering language development* and to provide children with the interactions and materials that promote learning. (Shonkoff & Phillips, 2000, p. 162, emphasis added).

Even the authors of one of the frequently cited studies leading to the recommendation to "talk to your baby" did not advocate that professionals ask mothers to talk to their children more. Their proposed solutions to problems associated with the limited vocabularies of some groups of young children focused much more on the economic and socio-political climate of our country than on trying to change how individual mothers naturally interact with their babies (Hart & Risley, 1995).

Rather than sharing generalized recommendations, such as "talk to your baby," infant-family practitioners can join with families to understand how the child-rearing practices in which they naturally engage support the child's current and future developmental needs.

Infant–family practitioners have a role as mediators between the culture of research and the cultures of families. Rather than sharing generalized recommendations, such as "talk to your baby," we, as practitioners, can join with families to understand how the child-rearing practices in which they naturally engage are supportive of the child's current and future developmental needs. We can also support parents as they identify what they might want to do differently—from what their parents did, from what they are currently doing, or from what we might do—to better meet the present and future needs of their children.

Self-Awareness First

We know that our beliefs and perceptions are strongly influenced by the culture in which we were raised. Yet we are often unaware of *how* culture influences our beliefs and perceptions. This is particularly true of beliefs about how to care for children. Lieberman (1990) calls the "unconscious transmission of adaptive child-rearing mechanisms" *cultural transparency* (p. 103). She and other authors indicate that this unconscious transmission promotes cultural continuity and child survival. However, for infant–family practitioners, lack of awareness of why we believe and see things as we do with respect to child rearing has two relevant implications for our work:

1. In order to begin to understand people from other cultures, we need to understand our own culture as if we were outsiders to that culture.
2. If, because of cultural transparency, families can't easily tell us why they raise their children as they do, practitioners must avoid failing to value family practices that are different from our own (Lieberman, 1990) and find ways to listen and join with parents.

Talking With Parents About Communication

The infant–family practitioner can join with the parent to better understand each other's communication styles. For example, does a certain parent tend to communicate using comments rather than questions? Might questioning be perceived as intrusive by this parent? Often in the early stages of forming a relationship it is helpful for the practitioner to consciously mirror the verbal and nonverbal communication of the parent. Use of mirroring between the practitioner and the parent parallels the desired mirroring between the parent and baby. Using this strategy, the practitioner notices and wonders about such things as: How is baby sending cues? How is parent reading and responding to those cues? What does baby do when the cue is responded to as intended? How about when that does not happen? How do the parent and baby communicate using touch, eye gaze, movement, sounds, and gestures? In addition to the communication that happens directly between the parent and baby, what other communication is the baby exposed to both directly and indirectly? How does he respond? These observations and hypotheses are explored with the parent in a way that reflects the parent's preferred communication style.

Picture a mother sitting on her couch while her baby is sitting surrounded by toys on a blanket on the floor in front of the couch. The practitioner notices that baby cranes her neck looking toward her mother for approval once she has successfully grasped a toy. Your earlier experiences with this mother have indicated to you that she does not seem to respond comfortably to questioning. If the mother does not acknowledge the baby's communication attempt, you, the practitioner, might comment, "She (baby) is really working hard to get your attention." After a pause, you can use the information gained from the earlier mirroring process with the parent to guide you throughout the rest of this interaction.

By noticing and commenting on the communicative strengths of the parent and baby, practitioners are laying the groundwork for an exploration of how those strengths help the baby participate effectively in his current environments. Some babies learn to be loud and persistent in their calls for attention. Other babies learn to make funny sounds or cute facial expressions to engage caregivers in interaction. When we wonder with the parent about how

the baby learned to do certain things and why the baby does what he does, we are joining with the parent to speculate on the baby's experience and motivation. We are strengthening our shared understanding of the "hows" and "whys" of this particular baby and connecting that information to the context of his current learning environment.

What About the Future?

Each of us thinks about the future in different ways—influenced, again, by our culture, family experience, and other factors. For some of us "the future" is next week. Others gaze at a baby and wonder about his future occupation. As relationships develop between parents and professionals, we each get a clearer point of reference about the other person's way of thinking about the future. We can say to the parent who is very focused on the here and now, "Listen to those funny sounds! What do you call that noise he's making?" Depending on the parent's preferred communication style, you might go on to say, "I don't know why, but some people call that sound 'raspberries.' Have you heard that before?" You might ask questions like, " How long has he been doing this? What is he trying to tell us? What do you think he'll do next?" We can shape our discussions and speculations toward a shared sense of developmental progressions. We can help parents learn how skills that develop earlier are built upon for later, more sophisticated skills. Some parents may be interested in thinking about what baby's life will be like as his world expands outside of his home. What will it be like when he goes to stay at Auntie's house? How will he get his needs met there? Is participation in a child care or Head Start center in this baby's future? What is the parent wondering about? What do they want to see for their child in those future settings? Recognizing the incredible influence that culture plays on what practitioners and parents each perceive as language and communication is critical to our ability to talk with families about supporting communication with their young children.

In Conclusion

Erickson and her colleagues (1999) remind practitioners to "Ask, don't tell." A reflective infant–family practitioner knows that "asking" must involve a thoughtful internal process that occurs before any words come out of her mouth. When the practitioner engages in the thought processes and uses mirroring as described in this article she is better able to help families discover their own communicative strengths and work toward their children's success in future environments. To make effective practical use of research on communication, we must reflect on our own assumptions about child-rearing practices that support communication development. We must be ready to accept great variety in communication styles. This reflection and acceptance will best be supported through ongoing reflective supervision and mentorship. Barrera and Corso (2002) help us understand that diversity is a given—it is always present in our work with families. We must support one another to understand the dynamics of culture in order to do our work effectively.

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Joining American Indian Systems of Care:

The Complexities of Culturally Appropriate Practice

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Cultural communities are composed of generations of people in coordination with each other over time, with some common and continuing organization, values, understandings, history, and practices that transcend particular individuals. At the same time, individuals and their generational cohorts change community traditions, with changing times and changing conditions. (Rogoff & Angelillo, in press)

Changing times and conditions in tribal communities are clearly evident in American Indian/Alaska Native Early Head Start (AI/AN EHS) programs. Since EHS began in 1996, AI/AN EHS services have been available to support low-income expectant families and children from birth to age 3 years. Currently, 42 tribal communities located in 19 states provide EHS services to nearly 2,000 infants, toddlers, families, and pregnant women.

The complexity of providing culturally appropriate services for American Indian and Alaska Native children and families is suggested by the number of cultures and multitude of languages that are found in tribal communities (Willis, 1999). At present, nearly 500 tribes reside on tribal lands in urban enclaves or on one of 286 reservations in the United States (Iverson, 1998). Each tribal EHS program reflects elements of the individual child's home, family, culture, and language in its curriculum and caregiving practices. Many tribal leaders and educators emphasize the importance of building strong tribal identity among the families and young children enrolled in AI/AN EHS. Programs have created curricula that are based on a synthesis of traditional prenatal and child-rearing practices, native language and educational approaches, and state-of-the-art child development knowledge. This synthesis is designed to reduce discontinuity between the infant's home and the EHS program environment.

AI/AN EHS staff often solicit the wisdom of tribal elders to guide the process of engaging EHS families in a culturally sensitive manner. The spirit of collaboration and flexibility is vital to this work, especially when considering the diversity of

at a glance

- Nearly 500 American Indian tribes live on tribal lands in urban enclaves or on one of 286 reservations in the U.S.
- The Touchpoints Center has begun to work with eight American Indian Early Head Start programs.
- "Use the behavior of the child as your language" and "Recognize what you bring to the interaction" are two Touchpoints principles that are particularly applicable to this work.

family practices that exist within each tribal community. Moreover, a dynamic tension exists between traditional cultural values and the European-American child development practices characteristic of EHS. For example, in many American Indian and Alaska Native cultures, the cooperative nature of the group takes precedence over the prominence of individual development (Paul, 1991; Little Soldier, 1992).

Joining a System of Care: The Touchpoints Approach

Recently, the Touchpoints Center has begun to add to the synthesis of perspectives in its work with eight American Indian EHS programs. Touchpoints, an approach to working with families of young children that is based on the practice and research of T. Berry Brazelton (1992), is a means by which practitioners of various disciplines join the system of care around a child at periods of predictable disorganization in development. Since 1996, the Brazelton Touchpoints Center has collaborated with training teams in 50 communities — including 2 Native American communities (Navajo, Gallup, New Mexico, and Ojibwe, Red Cliff, Wisconsin). In 2002, the Center began to work with nine additional EHS programs: Southern Ute, Ignaciao, Colorado; Prairie Band of Potawatomi, Mayetta, Kansas; Blackfeet Nation, Browning, Montana; Rocky Boy Chippewa Cree, Box Elder, Montana; Confederated Tribes of Salish and Kootenai, Ronan, Montana; Port Gamble S'Klallam, Kingston, Washington; Pueblo of Laguna, Laguna, New Mexico; White Earth Band of Ojibwe Nation, White Earth, Minnesota; and Suquamish Nation, Suquamish, Washington.

The American Indian/Alaska Native Touchpoints Initiative focuses its efforts on three critical tasks:

1. to optimize child development and support the social and emotional well-being of children within the family while at the same time learning about and utilizing the unique culture and strengths of American Indian/Alaska Native communities;
2. to nurture and build caring, collaborative relationships among child care and health practitioners, parents, and children to support tribal families with young children; and
3. to collaborate with tribal leadership to preserve and promote cultural integrity within each community that is adopting the Touchpoints approach.

Fundamental to our approach is the notion of joining a system of care. As we begin this work we recognize that we bring ideas and practices that are based in European-American culture. We further recognize that past European-American programs have denied the worth of American Indian cultural practices and failed to support communities in raising healthy children. Indeed, over several centuries communities have been forced to concentrate much of their child-rearing energy on helping children adapt to a hostile or oppressive environment, distorting their child-rearing practices.

Touchpoints–trained practitioners engage in a dialogue with a family that uses the child's behavior in relation to the parent's beliefs about the behavior. This is done in order to address parental concerns about child-rearing and development.

Touchpoints training involves a reflective process in which practitioners become aware of parents' beliefs and their developmental agenda for their children. Rather than providing advice or guidance that is based upon European-American developmental norms, the practitioner engages in a dialogue with a family that uses the child's behavior in relation to the parent's beliefs about that behavior in order to address parental concerns about child-rearing and development. We embrace Small's philosophy:

> Every act by parents, every goal that molds that act, has a foundation in what is appropriate for that particular culture. In this sense, no parenting style is "right" and no style is "wrong." It is appropriate or inappropriate only according to culture (Small, 1998, p. 108).

In parallel fashion, as we work with Native American communities, we recognize that we are joining a set of community beliefs about development and behavior. We see our work as supporting healthy development within that framework, not replacing the framework itself. We agree with Weisner about the importance of giving "the child a specific culture in which to mature" (1996, p. 305). How a child is loved, fed, and believed in is defined by culture. As we train professionals who work with families of young children, both Native and non-Native, we are engaged in a process of discovery about children, their cultures, and ourselves.

Using Touchpoints Principles in Gallup and Red Cliff

The first steps in applying Touchpoints with Native American families began with the Navajo site in Gallup, New Mexico, and the Ojibwe site in Red Cliff, Wisconsin. In 1997, a team of three Navajo practitioners, representing both the Gallup Indian Medical Center and Navajo Nation Head Start, came to Boston for a week-long Touchpoints training. Subsequently two follow-up site visits were conducted to provide technical assistance to the team. In addition, the chief of pediatrics at the medical center came to Boston for individual training. Work at the Navajo site focused on collaboration between the medical community and the Native Head Start program.

In 2001, the Red Cliff Band of Lake Superior Ojibwe EHS Program was awarded a Fatherhood Demonstration Project grant by the Head Start Bureau. A multidisciplinary team from the tribal community attended the Boston training. As of this writing, more than 200 health care and early care education staff, parents, and community members in Red Cliff have completed the Touchpoints training modules in a community where 100% of the children age 3 to 5 years and 60% of the children age birth to 3 years receive HS and EHS services.

Lessons learned about the Touchpoints approach in work with these two tribes relate to the principles of practice that are central to the approach (Hornstein, O'Brien, & Stadtler, 1997; see Table 1).

Table 1: Touchpoints Principles of Practice

1) Value and understand the relationship between you and the parent.
2) Use the behavior of the child as your language.
3) Recognize what you bring to the interaction.
4) Be willing to discuss matters that go beyond your traditional role.
5) Value passion wherever you find it.
6) Focus on the parent–child relationship.
7) Look for opportunity to support parental mastery.
8) Value disorganization and vulnerability as an opportunity.

Use the behavior of the child as your language.

A core Touchpoint principle is *use the behavior of the child as your language*. After training, Ned Pablo, a Gallup team member and mental health clinician at the medical center, was increasingly asked by hospital maternity staff to demonstrate the behaviors of newborn babies with new families, using the Neonatal Behavioral Assessment Scale. The newborn Touchpoint is seen as the exemplar of the principle of using the child's behavior as your language in supporting parental mastery. To watch Ned conduct an exam with a family is to see this principle at work. He lets the baby's behavior do the talking. In demonstrating the baby's ability to orient toward the father's voice he supports the development of the father–child relationship.

In applying the principle *use the behavior of the child as your language*, talking about the behavior is often the currency of professional work with families. In Touchpoints training our demonstrations use a significant amount of language to interpret the health and behavior of the child, in particular the normative regressions that characterize development. However, a practitioner's attention to such regression must be communicated with care and sensitivity. In working with the Navajo we have learned that talking about fears may be problematic. At our second site visit one (nonnative) pediatrician noted that she was perceived negatively because she identified—gave a name to—a suspected but not previously acknowledged medical problem. Other nonnative pediatricians concurred and noted that direct communication about a child's developmental or medical concerns was often viewed with suspicion by Navajo families. At the same time these pediatricians delighted in sharing with parents the experience of the child's first laugh, an important milestone in traditional Navajo development. In our initial work with the Navajo then, we affirmed the value of using the behavior of the child as our language, but found that identifying negative aspects of health and development (normative regressions, developmental problems, or illness) is difficult when crossing cultural boundaries.

A similar concern is reflected in the Red Cliff community's adaptation of the Touchpoints training model. When the team train practitioners they present parallel Touchpoints and Native American principles. Two of the principles they discuss are: listening skills are valued over verbal skills, and how you walk the "Red Road" is of more value than what you speak (Rob Goslin, personal communication). These two parallel principles clarify for practitioners working with families at this site that communication is not based solely on language, and involves being with parents as they see the child's health and development. Clearly, our work with these programs requires particular attention to communicating via the language of the child's behavior, whether it be eliciting a first laugh at a well-child visit, demonstrating the orientation response at a newborn exam, or observing alongside a parent the child's first social interactions upon entry into a center-based EHS program.

Recognize what you bring to the interaction.

The Touchpoints principle that seems most relevant to our work in Native American communities is to *recognize what you bring to the interaction*. This involves self-reflection and, ideally, competent supervision. Our work with Native American communities puts this principle to a test. First, it requires us to acknowledge the cultural biases that we bring to these interactions. We bring ourselves. We bring the way we listen, our sense of time and space, our multifaceted ways of interacting with other people. From the minute we are born we learn how to regulate ourselves in relation to others of our culture. We are individual, for certain, but the individuality we bring to our work with Native Americans is in itself a cultural legacy. As Meredith Small (1998) has pointed out, no culture, traditional or modern, holds the human prescription for child rearing. As we carry our own beliefs into interactions with parents of other cultures, we must recognize that sleeping, toileting, feeding, and playing patterns vary tremendously both between and within cultures. Our job as practitioners is to discover the child and what is best for the child within the child's system of care.

Second, we bring our individual interpretations of American history coupled with our personal sense of social justice. Europeans came to this country seeking political and religious freedom. Since the first contact, indigenous people were subjected to the harsh practices and policies of the colonizing settlers. Treaties were made and broken with sovereign Indian Nations as federal policy supporting the socio-economic and political and religious systems of the majority culture evolved (Iverson,1998). The impact of oppressive federal policy yielded devastating effects on many Native American families. Tribal communities were forced to leave their homelands. Children were removed from their families and assimilated in boarding schools, forbidden to speak their native language. The memories and scars of maltreatment persist in the oral traditions of today. The evidence of determined effort to assert tribal sovereignty and claim tribal tradition is seen in the importance of the stories of the past (Smith, 2001). It is also quite apparent in the present. The resurgence of native language education and cultural practices is indicative of the power of resilience and pride in tribal identity that community members share.

Third, we bring our role as service providers and the power imbalance that this implies. In establishing an authentic conversation with parents, and, in parallel, with community trainers, about child-rearing challenges, we must acknowledge parental expertise about their children and expertise about cultural child-rearing beliefs. We must abandon some professional agendas based upon training in European–American traditions in order to affirm parental competence based in traditional cultural ways. One of the paradoxes that we encounter in this work is the agenda of some Touchpoints trainers to reaffirm traditional practices in their communities. We agree that traditional practices must be acknowledged, understood, and reaffirmed. At the same time, in individual practitioner–parent interactions these professionals may discover that a particular parent may be choosing another child-rearing approach (e.g., reflecting the values of the Anglo culture or adopting fundamentalist Christian beliefs). As Rogoff reminded us, cultures are dynamic and the child-rearing practices change with time.

In conclusion, as we begin our program of training and technical assistance in working with these Native American communities we are rethinking what we bring to these interactions. We confidently bring knowledge about child development, our personal beliefs about caring for young children, and a commitment to respectfully join a system of care. As Jeanne Christopher, Director of Early Childhood Services for the Confederated Tribes of Salish and Kootenai has advised us, "We don't want you to teach us anything. We do want you to learn with us as we work with our babies and our families to strengthen our communities."

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PHOTO: FLORENCE SHARP

CULTURAL MODELS FOR EARLY CAREGIVING

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Kira was born today.

We may not know the time, place, or circumstances of her birth, but we can assume that the event has triggered a series of responses among the people in Kira's immediate environment. *What* parents, family, and friends do reflects beliefs in her community about what a newborn infant needs to support and sustain her new life. Expectations that such care will be provided are ingrained, through custom and ritual, in the lives of the people in Kira's community. *Who* should do what is also clearly defined and understood. Kira's mother's sisters will provide care and assistance to the mother and baby. Of course, Kira's maternal grandmother will be the primary advisor to her daughter and teach her how to nurse the baby, arrange the home environment, and provide daily caregiving. Kira's father returns to work in order to provide for his family. The roles assumed by these family members are organized expressions of the family's culture, the beliefs and values shared by the members of her community and adhered to almost unconsciously. The responses that greet Kira's birth have been developed, promoted, and perpetuated by members of her community for some time—perhaps centuries.

Like Kira, each of us was born into a "cultural niche" that began to regulate our development even before our birth. Beliefs about pregnancy, birth, and child-rearing that surrounded our mother, father, and family guided them to make particular decisions about our arrival and the immediate environment that would greet us (Harkness & Super, 1996). Yet the underlying meanings of these behaviors, customs, and rituals may have been so taken for granted by our family that they may never have spoken to us about them directly (Ogbu, 1990).

In the last decade, researchers (Harkness & Super, 1996; Lynch & Hanson, 1998; Gonzalez-Mena, 2001; Harry, 2002; Barrera, this issue, p. 8) have explored the role of culture in development and strategies for incorporating a culturally responsive approach in infant–family practice. The field is moving beyond a generalized respect for the diversity of child-rearing beliefs and practices among different ethnic,

at a glance

- Cultural models help people translate belief into behavior.
- Cultural models link roles to specific child-rearing practices (a good mother does this).
- Cultural models prescribe responses to children's expectable behavior (when a baby cries, a good parent does that).
- Cultural models guide practitioner's professional interactions; practitioners must continually reexamine the sources of our knowledge and reevaluate our practice to ensure that it is relevant and unbiased.

racial, and cultural groups toward specific strategies that help us understand the meanings that underlie the ways that caregivers respond to infants. Practitioners who work with families with infants and toddlers need to acknowledge the existence and power of family and community beliefs about what is needed for healthy child development and who should provide it. This understanding will make it possible for support and intervention to be family-centered and aligned with parental goals. Yet if parents are not always conscious of their deepest beliefs, how can practitioners learn about them?

The notion of *cultural models* (Ogbu,1990; Holland & Quinn,1987) articulated by anthropologists, is a useful concept in the infant–family field as well. As this article shall describe, cultural models represent one more way to think about the meaning of behavior—especially caregiving behavior. The concept of cultural models is as relevant to professional self-reflection as it is to careful observation of children and families. Indeed, a cultural model of culturally responsive infant–family practice could become a driving force for productive engagement with families.

Practitioners who work with families with infants and toddlers need to acknowledge the existence and power of family and community beliefs about what is needed for healthy child development and who should provide it.

What Is a Cultural Model?

According to anthropologists (see sidebar), cultural models help members of a culture organize the knowledge of their universe, interpret events, and know how to act in the situations they encounter. A cultural model is constructed over time from recurring historical events or experiences as well as contemporary influences. A cultural model is perpetuated when it sustains the prevailing values of the community and has continued relevance for meeting their goals. Cultural models are not static, but are constantly modified and revised, depending on the environment and circumstances.

Definition of Cultural Model

"A cultural model is an understanding that a people have of their universe—social, physical, or both—as well as their understanding of their behavior in that universe. The cultural model of a population serves its members as a guide in their interpretation of events and elements within their universe; it also serves as a guide to their expectations and actions in that universe or environment....It is constructed from what members of a population say (their 'talk') as well as from what they actually do (their 'behavior' or 'action')." (Ogbu, 1990, p.523)

Finally, people may draw upon several cultural models at the same time to interpret and respond to environmental demands (Harkness, Super, & Keefer, 1992).

A number of terms in contemporary usage are similar to the concept of cultural model—for example, blueprint, schema, paradigm, or framework. Perhaps the closest is "code of behavior," since it includes the idea of beliefs and principles ("code") and the reference to specific actions ("behavior"). Consideration of these terms can assist us in our application of the concept of cultural models to our professional work and personal lives.

Cultural models help people translate belief into behavior. Consider, for example, a culture that believes in the value of independence and self-reliance. The cultural model of a good mother, then, would be someone who encourages her children to be independent. Her strategies for encouraging independence might include insistence on learning to sleep alone and promotion of self-feeding. Her behavior might include letting an infant cry at night for a prescribed period of time or remaining unperturbed as a baby demonstrates that eating a banana is at best an emerging skill. (Needless to say, an observer guided by a different set of beliefs and, therefore, a different cultural model of "good mother" might be appalled at such "caregiving.")

In addition to linking roles to specific child-rearing practices, cultural models also prescribe responses to children's expectable behavior. Thus cultural models for caregiving related to infant crying exist around the world, varying according to the beliefs of each group (Small, 1998). Tolerance of extended crying could be believed to be important for the development of communication, self-expression, and self-control. In this case, parents would be expected to respond to crying only after a prescribed period of time (5 minutes). Various activities would be followed to adhere to this model. Maintaining physical distance, use of pacifier, or swaddling would be acceptable activities or "scripts" that would promote independence. On the other hand, a cultural model which sees secure attachment as the most critically important aspect of the relationship between child and caregiver might actively promote the baby's dependence The model would logically lead to practices such as carrying a baby for extended periods or co-sleeping, reflecting the belief that these actions would promote secure attachments to the caregiver. In both of these examples, the caregiver is guided by knowledge (the cultural model) of infant development that is expressed in the strategies she chooses to respond to the baby. In this way, the cultural model is the driving force or motivation for her actions (Harkness et al., 1992).

Multiple models co-exist and are used by parents as needed. Parents may use one model for feeding a baby

(good mothers nurture their babies through feeding, holding them close, and responding to them during nursing or bottle-feeding), and another for promoting the infant's learning (good mothers provide a variety of stimulating experiences for their baby). If the baby becomes ill, a model can guide parents in appropriate responses. Cultural models are used differentially within families and among the children. Developmental age, gender, and cultural expectations for children's development and success are some of the variables that affect how parents apply cultural models. The model that informs the type of care used for an infant (very young children should be cared for by family members) may eventually be abandoned as the child grows into a new developmental phase that requires organization of caregiving behavior according to a different cultural model (school aged children can be cared for by others).

The concept of cultural models helps us to understand the beliefs and motivations that underlie behavior and practice. When we realize that cultural models guide parents' caregiving strategies and practitioners' professional interactions, we gain cultural understanding of ourselves and the families with whom we work.

In my experience, it is easiest to understand and begin to apply the idea of cultural model through stories. Here are three.

What's a "Good Mother" To Do?

How do parents know "what to do" with their babies? Consider Rita as she enters the Early Head Start Program for a weekly visit with her Family Support Worker, Maia.

> *Rita arrives at the Early Head Start program proudly carrying her son Jimmy in her arms. She likes coming to the Early Head Start Program for the support she receives from Maia, her Family Support Worker. She is often reassured by Maia about how well she is caring for her children. She has talked with Maia about Jimmy's crying, about how to ensure that Jimmy is a 'good eater,' and she has listened to ways she can respond to his biting. Today, Rita wants to get some advice about how she might deal with Jimmy's night waking.*

Rita is drawing upon several cultural models to guide her in caring for Jimmy. She has observed these in her family and she has heard about them from her mother when she advises her about caregiving. In fact, before Jimmy was born, she had already practiced them when she babysat for her nephews. We understand that as people transition into parenting, they draw upon cultural models for behavior that is relevant, meaningful, and expected of parents in their particular social-cultural group (Harkness et al., 1992). Although she doesn't talk about them directly to anyone, Rita uses cultural models for behavior every day without consciously thinking about them. If she was asked about them, she might not be able to describe them. With some probing, she might talk about why they are important and become aware that they exist. When she encounters information or receives advice that conflicts with one of these cultural models, she will become more aware of her thinking about them. She might react to the new information by ignoring it and reconfirming her ideas about what she is currently doing. Or she might consider revising one of her strategies, which would also lead to a revision in one of her cultural models.

For example, Rita says she wants her son to be independent, but the strategies she chooses to promote this will need to be considered in the context of her existing beliefs. Should Maia suggest that Jimmy be allowed to feed himself, Rita may appear to resist this idea, as it conflicts with her cultural model of the good mother. In Rita's family, the idea of "good mother" implies that she feeds and holds her baby to ensure that he is getting enough food. This way the baby knows her and develops a close attachment to her. If her

Insights from Cultural Studies

Infant-family research and practice draw on a multidisciplinary knowledge base. Cultural studies, grounded in anthropology, use methodologies that are well suited to our field. More specifically, ethnographic methods of research are designed to discover and describe existing cultural models, including the ways that parents organize caregiving and provide particular experiences for their child in order to ensure the transmission of cultural values, and provide continuity in caregiving. Most importantly, ethnographies describe the *meanings* of events, experiences, and child-rearing practices to members of the cultural group being studied (LeCompte & Schensul, 1999). Ethnographers collect information through observation, interviewing, reflection (field notes), and artifacts (records, photos).

Practitioners working with infants, toddlers, and families are already using ethnographic methods in their work. Careful observation of caregivers with their children, in-depth interviewing, and review of family information records can begin to reveal patterns of recurring action and thought for each family. Documenting family needs and children's developmental change over time, and reflective supervision and journaling are additional ways to record information that can be reviewed systematically to uncover cultural models. Practitioners can test the accuracy of their interpretations—in other words, the strength of their hypothesized cultural model—by asking caregivers about the motivations and meanings of caregiving behaviors and through continued reflection and inductive analysis of the information they gather. In research, qualitative methodologies now include systematic analysis of data for cultural models (Skinner, Rodriguez, & Bailey, 1999).

family support worker proposes a strategy (self-feeding) that is derived from a cultural model that differs from Rita's, the worker will need to be sensitive to her reaction and explore her perspective. What Maia might consider resistance to developmentally appropriate practice could be seen as Rita's reconfirmation of her cultural code.

While both Maia and Rita might agree on a developmental goal for Jimmy (sleeping through the night), they might differ in their ideas about acceptable strategies to help Jimmy reach the goal. In this case, Maia and Rita could be drawing upon different cultural models for sleeping—one promoting dependence, the other promoting independence. They both agree on the need to change Jimmy's behavior, but Maia might suggest a strategy that violates Rita's understanding of what she needs to do to nurture her baby's dependence on her. If Maia can see the importance of identifying the cultural models that guide Rita's behavior, she will have the insight to support Rita by suggesting alternative caregiving strategies that are consistent with her existing beliefs, and therefore acceptable. This understanding will also contribute to the developing positive relationship between Maia and Rita.

When the Unforeseen Occurs: Feeling "Scriptless"

Cultural models for early caregiving are developed on reasonable expectations about the infant, as defined by the family's culture. But what happens when expectations are disrupted? Where do parents find alternative models to organize their behavior? What might motivate them to consider alternative ways of caring for their baby?

> *Anna and Frank became parents again last week when their daughter Maggie was born at 6:30 on Thursday evening. Thrilled to have a third daughter, they began to call their family and friends with the good news. The next morning, a doctor approached them with information about the baby's health that was unexpected and troubling. Maggie had a medical condition that would have a long-term impact on her development. As the next minutes, hours, and days passed by, Anna and Frank's life changed. Their expectations of a healthy baby were suddenly altered and they began to respond to these changes the best way they could. The phrase "What should we do?" was ever present in their thoughts and actions.*

In the following days and weeks, these parents will seek guidance from those around them as to how to respond to this situation—how to meet Maggie's unanticipated needs. If Anna and Frank need to consider strategies that are not part of a familiar repertoire, they will have to decide to adopt new ways of parenting. Some models will be abandoned, new models will be created, and others will be sustained. Every day, around the world, families experience this challenging situation. The family's culture will contribute to how the family responds to a crisis and will serve to guide their actions.

In my research with families of infants with disabilities in Ireland, I explored the ways that culture informed, guided, and supported families through the early days of learning about their infant's diagnosis (Finn, 1998). Using ethnographic methods (observations, interviews, and focus groups) to identify and describe the experiences of these families, I was able to uncover cultural beliefs and models that assisted parents in their adaptation to this crisis. I discovered that following the news of the diagnosis of their infant, every parent described their response to this devastating news in almost the same words: "We didn't know what to do. We didn't have any experience with this." I called this being left "scriptless."

In time, each family drew upon other cultural models to provide guidance through the crisis. In this setting, these models were the roles and responsibilities of mothers and the use of talk (in particular ways) to access support and information. Parents used these scripts for behavior as they worked to revise some of their existing cultural models of good parenting and create new ones. Anna's understandings of what she needed to do (as a good mother) to care for Maggie provided her with the motivation and strength (she was confident about how to be a good mother) to seek ways to respond to Maggie's special needs. Drawing upon existing models of parenting and using talk to get information and support provided parents of newly diagnosed infants with time to consider new strategies and revise their guiding models of parenting (Weisner, Matheson, & Bernheimer, 1996). Once these were in place, a new level of confidence and coping was possible.

Cultural Models of Professional Practice: Codes of Conduct

Parents draw upon received cultural models to guide their parenting but can revise them according to the demands of the environment. In the same way, practitioners in the infant–family field use cultural models to guide our work—reflecting and revising as we grow and learn. The knowledge and understandings that we bring to our work with families draw primarily upon two sources: our personal experience and our professional training. These sources of knowledge converge to create new cultural models that reflect the code of conduct of our profession. The beliefs and values specific to our profession are embedded in our training. We learn to demonstrate our competence by providing evidence of these beliefs and values in our written and clinical work.

Professions construct cultural models of practice to reflect the beliefs and values of the profession. Professionals in the field of early childhood education (a cultural group) value independence, verbal communication, and social interaction. Teachers learn strategies to shape the behavior of children according to these values—for example, facilitating children's engagement with their environment through interactive play according to Developmentally Appropriate Practice (DAP; Bredekamp & Copple, 1997) is an example of a cultural model for early childhood educators. DAP provides a framework that embodies beliefs and values about

learning. Curriculum methods guide teachers in the specific steps involved in creating a classroom environment, choosing materials, and interacting with children in ways that reflect these values. In turn, teachers develop goals and strategies that are consistent with DAP.

Every profession in the infant–family field could be described as a cultural group, with its members sharing beliefs and values, and following articulated rules for behavior. In work settings where practitioners from different professional disciplines work together, we strive to accommodate to the rules and behaviors of our colleagues. We are challenged to refer continually to our professional codes while we adapt to both the explicit and implicit rules and expectations of our work setting. To function effectively as a team member, each practitioner must be aware of her own cultural models and discover those of her colleagues. Observation, inquiry, and reflection encourage discovery and, when appropriate, the creation of a new model that reflects the unique culture of a team.

Identifying the cultural models that guide caregivers helps us to understand potential sources of conflict between cultural models, and then to devise intervention strategies that are consistent with parents' goals.

Mary has just graduated from a Bachelor's degree program in Occupational Therapy (OT) where she has learned about clinical practice and code of conduct for her profession. Following two internships, she tentatively begins her professional work as an OT on an Early Intervention team. In the first days of her job, she begins to gather information about what is expected of her in her role as an OT, as well as what is expected of her as a member of the staff of the Early Intervention program. She gathers this information by observing, asking questions, talking to the other staff, and participating in an orientation program (reading materials and lectures). She reflects on what she is learning and to understand the cultural models of "professional-as-consultant-to-the-family" and "transdisciplinary team" that guide the program. She willingly decides to modify her behavior in order to conform to these models, which reflect her values, and uses reflective supervision to do so. Mary's principled flexibility and ability to adapt her behavior to fit new cultural models will contribute to her successful integration into the culture of the Early Intervention program. To the extent that the program's cultural models in fact meet the needs of the children and families it serves, Mary's adaptation will also contribute to her professional effectiveness.

Cultural Models and Cultural Responsiveness

In the last decade, the infant–family field has been trying to become more culturally responsive. Practitioners have recognized the importance of identifying, through personal introspection, our own cultural background as well as the beliefs and values that inform our practice. Cross-cultural literature and research on how parents raise their children around the world have taught us about diversity in parenting (Nugent, 1994). We recognize our need to continually reexamine the sources of our knowledge about child development (Harkness, 1992; Rogoff, 2002) and to then reevaluate our practice to ensure that services are relevant and unbiased. We are developing guidelines for asking the parents with whom we work about the beliefs and values that guide their child-rearing.

We observe the expression of cultural models when we engage with families to support them in parenting. Since we have recognized the need to move toward cultural competence, we have begun to identify the existing beliefs and values that families have about parenting and child-rearing. If we can systematically organize this information through skilled dialogue with each family, we can begin to identify the existing models that guide parents.

In my own teaching and clinical work with infant and family practitioners, I strive to incorporate respectful and culturally responsive interaction and understanding. I am continually reminded of the complexity of this issue as I observe my students as they begin to modify their thinking and incorporate this model into their work. I also have observed staff of infant–toddler programs struggle to incorporate cultural competence, cultural responsiveness, cultural sensitivity, and skilled dialogue in their work. They recognize the need to identify and understand the different beliefs that underlie diverse parenting styles and strategies, but they remain unsure about how to proceed. "Tell me how to do this," they ask. Perhaps they are looking for a new script. They want to know how to make sense of what families tell them. They want to understand the underlying meanings and motivations of each family's hopes and expectations for their children.

Identifying the cultural models that guide us is part of the personal introspection required of culturally competent practitioners. Identifying the cultural models that guide caregivers helps us to understand potential sources of conflict between cultural models, and then to devise intervention strategies that are consistent with parents' goals. Cultural models provide a way for us to understand how cultural beliefs and values are expressed in child-rearing through deliberate strategies that parents (and other members of their cultural group) use to promote their culture, heritage, values, and preferred behavior in their children.

Consideration of cultural models can help us provide coherence to the various forms of information that we are gathering about families and organize our interpretation of that information. Organizing and ongoing reflection upon what parents tell us about their strategies can help us discover

their cultural model for caregiving, and then compare it with the cultural models that guide our own practice.

Practitioners in the infant–family field recognize the richness and opportunity available to us in our work with families of diverse ethnic, racial, and cultural groups. We can learn the different ways that parents provide care for their children when they are all striving towards similar goals—happy and healthy children. We can use that knowledge to construct a cultural model of culturally responsive practice—designed to support families in their caregiving and assist them in meeting their goals for their children.

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Barriers to Achieving Change:

Dynamics of Social and Economic Differences in an Early Head Start Program

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What does it mean to change? Infant–family practitioners and the families with whom they work may both want to change children's lives for the better. They may have similar ideas of what kinds of change are most important. But if practitioners and families are going to work productively, both parties should be clear on exactly what it is they are trying to alter. A communications barrier between practitioner and family may slow the pace of change or may even prevent them from making effective change. In one Early Head Start (EHS) program, the communications barrier that I observed between home visitors and participating families seemed related to differences in social class and economic circumstances between the two groups.

Considering Social and Economic Difference

Discussions of diversity and of "cultural competence" as a way of identifying difference and finding common ground often assume ethnic diversity. They seldom take into account the social and economic diversity of our society. Yet infant–family professionals need to consider the possible effects of social and economic difference between providers of service and the families who receive support. By exploring social class and economic circumstances as aspects of cultural difference, service providers may identify barriers to communication and work around them, becoming more effective in the process.

In a recent qualitative study of families participating in an EHS program (Hallock, 2002), I discovered that the notion of effecting "change" in parent–child relationships meant different things to EHS home visitors and to participating families. In the study, I used the strategy of participant observation to embed myself both in the experience of families who were living in poverty and in their relationships with EHS home visitors. I sought to understand the experience of families and the nature of relationships between home visitors and families when social class and economic

at a glance

- This qualitative study looked at home visitors and program participants who were ethnically similar but economically and socially diverse.
- Communication barriers between these practitioners and families may be related to differences in social class and economic circumstances.
- Barriers to achieving shared goals also included: 1) the meanings home visitors and parents ascribed to each other's role; and 2) the manner in which they negotiated their relationships.

circumstances separate them. I participated in the River City[1] EHS program for 1 full academic year (September 2001 to June 2002) alongside families, spending numerous hours at the program center as well as in family homes to observe family experiences and family–home visitor interactions. Additionally, I conducted in-depth interviews with 5 home visitors and 9 parents who participated in the River City EHS program. Although the experience at River City EHS cannot be generalized to all infant–parent programs, the study does suggest cultural differences and barriers to effective practice that may be present in other programs.

Cultural differences related to social and economic circumstances were evident in the River City EHS program. The 5 home visitors who participated in in-depth interviews described themselves as middle-class. Individual home visitor salaries were between $10,000 and $19,000. However, family incomes ranged from $40,000 to $79,000. While home visitors paused and generally took several seconds (even minutes) to respond to a question about family income, all of them quickly identified their social status as "middle-middle class." In addition, the home visitors told me that they had been born into this social niche. They had not reached the "middle-middle class" through upward mobility.

In contrast, the families with whom the home visitors partnered met the federal guidelines for poverty. Moreover, selection criteria for families in this EHS program included the presence of "risk factors"—for example, maternal age, education, homelessness, disability, dependence on public income supports, and other psychosocial characteristics that are commonly perceived to put children at risk for developmental delay or learning problems. Of the 9 parents in this study, 7 participated in structured in-depth interviews. The 2 remaining parents participated in an ongoing, less formal interview format. Parents were not directly asked to identify their "social status;" however, I asked them in which social group they saw themselves. Some parents did not identify themselves with a social group; others used terms such as "white trash" or "trouble-makers" to describe themselves.

In brief, home visitors and families in the River City EHS program were ethnically similar (white) but economically and socially diverse. They came together, however, on some common ground: Families and home visitors alike seemed to want to make change.

What Is Change?

One parent, Vickie, told me that she participated in the River City EHS program because she wanted to learn to be a good parent and to "change the cycle." She recalled, "I was a 'whore.' I was a 'bitch.' I was a 'mouthy brat.' My mother says she didn't [call me names], but I remember her doing it." Vickie said she wanted to parent her own daughter differently and to provide her with opportunities that Vickie did not have as a child herself.

[1]All locations and names have been changed to preserve confidentiality.

PHOTO: NANCY GUADAGNO

Another parent said she was participating in EHS so that her own parenting would be different from what she knew as a child. She believed that her involvement in EHS was a way to show her commitment to trying to make that change. This theme resonated among the parents who talked with me about their parenting goals—they wanted to be better parents for their children than their own parents had been for them. Parents seemed to believe that EHS provided an opportunity for them to learn how to be good parents and to have positive relationships with their children, that would be, perhaps, different from their own experiences as children. They wanted to learn how to parent differently than by following the models that their own parents had provided.

Like families, home visitors said that they were in the EHS program to "make a difference" and "make change" for families. In my interviews with home visitors, I asked them what brought them to their work with families and what they wanted to accomplish in their roles as home visitors. One home visitor explained: "I want to make a difference. I want to help children grow and develop as wholesome and honest beings…" The home visitor claimed that teaching the parents proper ways to raise their children when the children were in their "first years" would make an important difference for the future of the children, to make the children "wholesome and honest."

Another home visitor shared a similar sentiment, noting that the services provided by home visitors make a difference for others: "But the *family*—the whole *family*—benefits

from home-based [services]...If you make a difference in the *family*, that can be forever." When I asked another home visitor why she did the work of home visiting in EHS, she said immediately, "Because I like it!" She told me, "I do think we can make a difference." Home visitors seemed to believe that their relationships with families would help parents have positive interactions with their children, bringing about beneficial change for families in the process.

Barriers to Effective Change

Although families and home visitors had some goals in common—to create change by improving relationships for children—there were two apparent barriers to effectively achieving this shared goal. The greatest barriers appeared to be, first, the meanings they ascribed to each other's role in the relationship, and, second, the manner in which home visitors and families negotiated their relationships. Both of these barriers seemed on the surface to be more about communication than culture. However, I came to believe that the differences that created communication barriers between home visitors and families were, in fact, related to their social and economic differences. Home visitors born into the "middle-middle class" learned that they have the power to make change. Parents who had lived all their lives in poverty and who faced additional risks to well-being had a harder time learning to make change, seeming to be at the mercy of institutions and "helping" professionals.

Home visitors considered themselves social workers and teachers. But all parents referred to their home visitors as teachers. They said that home visitors were "good" when they didn't "act like social workers (who think) they are better than you."

The Home Visitor's Role

When I asked home visitors what they *do* with families, they described their dual roles as social workers and teachers. One home visitor described her work as being "a mix between social work and early childhood education. It is a parent support—we're here for the parents. It's assessing a family's needs and using resources to help them."

Another home visitor described her work as a "hierarchy." When I asked her what she meant by that, she asked rhetorically, "What's more important? That the child has an hour of play and then has nothing to eat that night? And the next morning? You might not get your gross motor activity done or your speech activity done, but you were able to take them to the food pantry and get them hooked up or whatever. I feel *that* is more important...for the child, for the family, for everybody." She meant that helping families to access social services came well before assisting them directly with child development activities or changing negative patterns of parent–child interaction.

The home visitors viewed their most important activities with families as falling into the realm of "social work." They noted, however, that parents referred to them as "teachers," *not* social workers. Indeed, all the parents in this study referred to their home visitors as teachers. Additionally, one of the aspects that parents believed made home visitors "good" was that they didn't "act like social workers." When asked to describe "good" home visitors, one parent said, "They have to be friendly. They can't act like they are better than you. I mean...they're not a social worker. If they acted like they were, it would kind of be—that would be bad." When asked how it was that a social worker acts, the parent explained, "A social worker thinks they are better than you. And you're a bad person because you're on welfare and you don't work and...they talk down to you."

River City EHS home visitors perceived themselves as social workers first and teachers second. Parents seemed to view home visitors as teachers above all, who worked effectively with them through positive, comfortable relationships that did not resemble the relationships they had had with social workers. My impression was that parents viewed their home visitors as "teachers" rather than "social workers" because it was a more *comfortable* role for both parents and home visitors. Parents seemed to view their home visitors as teachers even when home visitors transported them to doctor's appointments and to the food pantry.

This perceptual difference of the role home visitors played in relationships with families may have affected how home visitors and parents negotiated their relationships with each other. The difference in perception may have been due, at least in part, to the manner in which home visitors and families in the program came together in the first place.

Explicit and implicit eligibility criteria

When I asked home visitors to describe appropriate referrals for the EHS program, they told me about eligibility criteria. One explicit criterion was income: Families whose income was at or below the federal poverty guidelines were eligible for EHS services. However, every family who met this explicit criterion could not be served, as there were more families who wanted to participate than the program could accommodate. Therefore, the program needed additional criteria in order to determine whom to serve.

When I asked home visitors how the determination was made, they told me about "risk factors" and "issues." One home visitor echoed a theme that resounded among all of the home visitors: The program gave priority to serving families who had "issues" such as "questions about parenting skills." I asked her to explain. She told me that if a home

visitor went out on a home visit to complete an application with a family and observed that the "the mother totally had no connection with the child" or "never talked to the child other than to just scream or to say negative things," then the home visitor would be "very concerned." The program described such concerns as psychosocial issues that put a child at risk for developmental delay. Other "issues" the home visitors told me about were concerns about family personal hygiene or household cleanliness that might put a family at risk for intervention by child protective services.

These implicit eligibility criteria helped create a communications barrier between the home visitors and the families because, in most instances, the home visitors did not explicitly discuss with families why they qualified for the program. To the home visitors it was clear that in addition to meeting the federal poverty guidelines, families selected for the program were "at risk" or had psychosocial issues that needed to be addressed. Families, on the other contrary, seemed only to understand the explicit criteria for their participation—income qualifications. Although parents and home visitors both stated that they wanted to create positive change, such as "changing the cycle" of negative parent–child interactions, the notion that program staff viewed families as "at risk" or "having issues" seemed to evade parents.

This difference in perception about the role of the home visitor and the lack of direct communication about home visitor concerns is demonstrated in the following vignette in which a home visitor told me a story about a "child development" activity that she does with families who have very dirty refrigerators that the home visitor wanted to get clean. I asked the home visitor if she communicated to the families that their refrigerators were dirty. "Not always. No," she laughed in response to the question. Then the home visitor continued, explaining: "If it is not a thing that [the parent] identifies—if the dirt is not something she identifies, I don't normally identify it. But I'll say, 'This is how I do shaving cream sometimes.'" The home visitor demonstrated a squirting sound and motion, laughing, so that I could visualize her with a can of shaving cream, talking to me as she would a parent: "All over the refrigerator! Spotless! And it smells good. I'll do the lemon-lime shaving cream because it smells good. And that might give her an idea, too. 'Sometimes when you guys are just hanging out here—it's cheap—this is something you can do. And, afterwards, your counter top is all clear because you've done this to it.'" This home visitor was telling me about hygiene goals she had for a family that seemed to be hidden in an activity that did not explicitly address her concerns. Instead, the hygiene goal was masked by the apparent child development goal, typically promoted by early educators for the development of sensory awareness and fine motor skills.

Negotiating relationships

But should the home visitor have told the family directly that their refrigerator was dirty? This question points to the fragile relationships between home visitors and families that home visitors described as "walking a tightrope." One home visitor claimed that a good home visitor was "someone who can listen" as well as be "someone who can direct." Pausing to reflect, she added, "...direct in a nondirective way." She continued, "You want to lead but not in the way to be pushy. You have to lead and follow, kind of. You can't be too pushy or too standoffish..." This was a theme that emerged from interviews with each of the home visitors about their relationships with families: that home visitors "walked a tightrope" with parents in the process of developing relationships. The home visitors described the tension of stepping very carefully as they built relationships with families, so that they would be welcomed back each week. If they were not, they could not work with families to implement goals—explicit or implicit.

Co-creating a Model of Change

In order for home visitors and families to achieve their shared vision of change, they need to be able to communicate clearly with each other—without getting tangled in the "tightrope." We need a model of change that is co-created by families and home visitors *together* so that parents can learn positive ways to interact with their children and home visitors can directly address the concerns that likely brought families and home visitors together to begin with. Cultural differences often create communication barriers; economic and social class differences between home visits and partner families seem to create communication barriers, as well, even if they are subtle. Until we learn how to overcome this barrier, home visitors are likely to continue disguising their sensitive objectives as goals more acceptable to families, continuing to walk a tightrope with families, and perhaps failing to achieve the change that families and home visitors both desire.

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PHOTO: NANCY GUADAGNO

WHEN CULTURES CLASH IN COURT:

Expanding Understanding and Building on Hope

CINDY S. LEDERMAN
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A recent visitor to my courtroom asked me what I see from the bench. "Human suffering," I told her.

In juvenile dependency court, judges must make life-changing decisions every day about the care of maltreated young children. In our courtrooms we see dysfunction in three cultures—the culture(s) of parents, the culture of the court itself, and the culture of our larger society. These three cultures need to work together to safeguard children's well-being. But sometimes it seems as if almost no one cares for the children who come before the court.

The Parents

Only a small percentage of the parents who come before me in court are, I believe, evil. The vast majority of the parents I see are impoverished and deprived—emotionally and environmentally. They have little hope for themselves and cannot even hope that their children will have better lives. Mothers don't understand the term "domestic violence;" what we consider spousal abuse is ordinary, expectable experience to them. No one loved or nurtured these parents. How could they possibly know a better way to care for their children? Most of the parents I see require intensive intervention before they are likely to be able to change.

However, some parents who appear in dependency court do have hope for their children. Often these are recent immigrants who come to the United States to give their children a better life. These parents may have beaten a child because he got his homework wrong or lied or misbehaved in school or stayed out all night. Yet they beat the child for what they consider a "good" reason—because they cared about his future. Indeed, the behavior of these parents may have been culturally appropriate in their homeland. If we can help them gain

at a glance

- Juvenile court judges see dysfunction in 3 cultures–the cultures of parents, of the court, and of the larger society.
- Judges should not impose their own morals and values but have a duty to educate parents about what our society expects of them.
- The traditional adversarial culture of juvenile dependency court is being replaced by the culture of the "problem-solving" court.

a better understanding of what children need, we can harness their hope.

The Juvenile Dependency Court

The chief "cultural" task for judges in juvenile dependency court is to refrain from imposing our own morals and values on the people who come before us. At the same time, we have a duty to educate parents about what our society expects of them. And when it proves difficult to help dysfunctional parents—when we have begged, cajoled, and threatened and they still won't or can't do what they need to do to get better themselves and care for their children—we need to be aware of our own anger. We need to deal with it ourselves, away from the bench.

The chief "cultural" task for judges in juvenile dependency court is to refrain from imposing our own morals and values on the people who come before us. At the same time, we have a duty to educate parents about what our society expects of them.

Unfortunately, an adversarial system is built into the current culture of juvenile dependency court—although this is the last court on earth that needs it. When attorneys seem to be adversarial for the sake of being adversarial, I confront them: They are on children's time in my court, and litigating without merit, only for the sake of prolonging the case, is not appropriate. Our job is to sit down together, look at the best interests of all parties, and move on. Observing that parents seem to be pitted against children in juvenile dependency court, some argue that a unified family court would be a positive cultural shift. I remain skeptical, however. Parents and children have distinct legal rights and responsibilities. In juvenile dependency court—and only in juvenile court—the law mandates that the child comes first. The juvenile court is the last institution on earth where the rights and needs of children are paramount.

A new culture is emerging in some juvenile dependency courts. This is the culture of "therapeutic jurisprudence" or problem-solving courts. In Miami–Dade County, defense attorneys, guardians ad litem, and others in the court have often made extraordinary efforts on behalf of individual children and families. Moving to a more systemic approach, a multidisciplinary group of lawyers, psychologists, social workers, domestic violence advocates, child welfare workers, and nationally known expert consultants helped us conceptualize the steps we could take to serve young children more effectively, and find the resources to do so. We obtained developmental assessments for infants and toddlers and links to early intervention. The Florida legislature has designated our court as an Infant and Young Children's Mental Health Pilot Site for the last 3 years. We created the country's first Juvenile Court/Early Head Start program (Lederman & Adams, 2001). We are demonstrating that a court can become a place of healing.

The Larger Society

The suffering I see daily is in large measure a product of contemporary culture. We have offered parents neither basic resources and services to help them nurture their young children nor the intensive treatment required to repair troubled relationships. Now, in many areas, institutions, like Child Protective Services, that are barely adequate are being asked to operate with significantly reduced budgets.

In Conclusion

Cultures are clashing in Miami–Dade Juvenile Dependency Court. And the culture of the court has changed. Our challenge now is to transform the larger culture, expanding understanding and instilling hope for children in all who are or should be responsible for our children's future. To create a culture that realizes that the children in dependency court who have been abused, neglected, and abandoned belong to *all of us*.

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Creating a Public Early Childhood Education System for a Pluralistic Parent Constituency:

The Challenge of First 5 LA

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The Los Angeles County Children and Families First–Proposition 10 Commission (also known as First 5 LA) was founded in 1998. The stated goal of the Commission is to optimize the development and well-being of all children—from birth until age 5—by increasing resources, ensuring access to services, and improving the ability of families, communities, and service providers to give kids the best possible start in life. As a commissioner for First 5 LA, and a long-time early childhood educator and advocate, I am in the enviable position of being able to help design an early childhood infrastructure for the largest county in the most populous state in the nation. No situation can be without its built-in challenges, and this one is no exception. Our opportunities have raised questions and presented us with choices which have significance for public policy and for the early childhood community as a whole.

Background

The activities of First 5 LA are funded by the taxes from tobacco products, a funding stream which is designed to disappear as people smoke less. Although the fund has generated a large amount of revenue, these resources are not sufficient to create and support a coordinated statewide system. The 2001–2004 strategic plan has identified school readiness as the overarching goal for Commission activities: This is said to include the other primary goals of (1) good health, (2) safety and survival, (3) economic well-being, and (4) social and emotional well-being. Examples of supported initiatives are

at a glance

- First 5 LA (formerly Prop 10) has identified school readiness as its overarching goal.
- Expansion of health care and Universal Pre-Kindergarten (UPK) are the highest-priority First 5 LA initiatives.
- Although early childhood professionals place a high priority on high-quality child care, surveys reveal public ambivalence about child care and strong support for UPK.

funding for home visiting programs, child abuse prevention, family literacy, healthy birth outcomes, and improving licensed child care.

The largest amounts of money have gone to two initiatives. The first is to expand health care coverage to all children ages birth to 5 years who are not covered by existing plans. These are essentially the children of the working poor: children whose parents work, but whose jobs do not offer health benefits for their families. The program is designed to be a comprehensive prevention model, offering well-baby care, dental care, immunizations, vision and hearing screening and care, health education, and pharmacy services.

The second is the Universal Access to Preschool and Early Care and Education Initiative (also known as UPK, for Universal Pre-Kindergarten). Although there are a number of objectives for this initiative, at this point the priority is support for 3–5 year old children who are not currently receiving educational services, are receiving an inadequate number of hours, or are in low-quality programs—hence the name "UPK." This initiative is the focus of this article.

Naming Our Dilemmas

As we worked to develop the UPK Initiative, we struggled with a number of issues.

Public ambivalence about child care

The First 5 LA Commission conducted extensive public surveys and focus groups to solicit input regarding the needs of children and families in the county, as there is a strong commitment to giving the public a voice in how funds are spent. The results of these studies indicated a range of opinions and values, as well as real ambivalence on the part of many respondents. Parents who need child care want that care to be affordable and of high quality. On the other hand, many people seemed to be uncomfortable with the idea of children being cared for outside their own home. This may stem from a deeply held belief that young children should be at home with their mothers. In any case, there were decidedly mixed reactions to the idea of establishing a state-sponsored system of child care for young children.

Additionally, there seemed to be a lack of appreciation of the educational and developmental importance of child care. Although early childhood professionals know that the curricular difference in a good child care program and a good pre-kindergarten program is essentially that of pacing and not content, the lay public does not share this perspective. The general perception seemed to be that child care is of primary value to parents, and preschool is of educational value to children. Pre-kindergarten, or preschool, is thought to have superior educational benefits relative to child care. At this point we are unsure as to why there is such a discrepancy between the value placed on preschool or pre-kindergarten experiences and that accorded to child care. We could speculate that some association is made between early preschool experience and future success at a prestigious college (and that these are privileges available to the upper middle class); or alternatively that education and socialization are understood to be the purpose of preschool, but not of child care.

The dilemma for the early childhood professional is that our knowledge and beliefs about child development would lead us to place a high priority on funding for universal access to high-quality child care. Working at Pacific Oaks, I have the opportunity to see the best possible child care environment for young children and their parents. Child–staff ratios are low; teachers are encouraged to follow the child's lead when it comes to developing activities. When a parent has a question or a concern, it is not difficult to find a teacher who is willing to discuss the issue. Parents are encouraged to share their observations and to increase their skills in being able to describe their child's behavior. These surroundings serve as a daily reminder of what all children deserve. Parents deserve this too, even if they have never imagined such a place for their children. To early childhood professionals, universal access to high-quality child care is as important as universal access to comprehensive health care. Yet the public did not completely share this point of view, and First 5 LA was committed to respecting the wishes of its constituency.

Competing social agendas

As stated, the funding available for First 5 LA initiatives is not enough to create and completely support an early childhood infrastructure for the county. Although Proposition 10 was designed to serve all the children of California, our commission looks at the highest priority areas, somewhat like the French *zone d'education prioritaire* (ZEP), or priority education zone. In the French Universal preschool model, ZEPs are identified so that the areas with the greatest social disadvantage can receive additional resources. The goal is to close the achievement gap. It is sound policy, when establishing a system to serve the general public, to begin where the need is greatest. However, our dilemma was that in attempting to meet a clearly defined need, we might contribute to the perception that the public system is primarily for those in need—for the poor. We are concerned that we may be contributing to the creation (or perpetuation) of a two-tiered educational system.

We hypothesized that by directing our limited resources to the areas where the need is greatest, First 5 LA would be able to demonstrate the success of our initiatives. However, doing so supports the stereotype that the state's, or the county's, primary responsibility is to provide programs for low-income families and children with special needs. As we create an early childhood infrastructure in this state, we do not wish to contribute to the belief that the public education system is for children whose parents cannot afford to send them to private programs.

Lack of full representation

The First 5 LA Commission has an executive director and a staff of directors, analysts, and program specialists.

The staff is responsible to the commission that is chaired each year by a member of the county Board of Supervisors. The commissioners are appointed by the five county supervisors, directors of the County Department of Mental Health, and Mental Health Services, and the County Office of Education. In Los Angeles County, there are ex-officio members who represent the County Commission for Children and Families, the Child Care Policy Roundtable for Child Care, the Children's Planning Council, and the County Inter-Agency on Child Abuse and Neglect. The Commission is composed of professionals and community leaders. It operates in a formal manner and holds meetings according to Roberts' Rules of Order on the 21st floor of a high-rise in downtown Los Angeles (where parking is quite expensive). This is not a situation that invites grassroots participation. There is some ethnic and racial diversity among the commissioners, but we are not truly representative of the county we serve.

Meeting the Challenge

We gradually came to understand that the challenge for the UPK Initiative was to make palatable the idea that government should be responsible for the care and education of young children. This is a function that is currently perceived as a parental responsibility. Moreover, the failure of government to assume responsibility for universally accessible good-quality early care and education is often framed as respect for parental "rights" and parental "choice." But few acknowledge that parents with limited information about the child care system or minimal resources for purchasing services will not be able to present their children with a full range of choices. The hypocrisy of "parental choice" is not a topic of public debate. So changing public and political attitudes are just the first steps in providing quality early care and education for all. Having states assume fiscal responsibility for such care in the midst of a recession is yet another challenge.

The role of leadership

At this point we are in the planning and implementation phase of the UPK Initiative. We have been fortunate to have a group of creative, dedicated, visionaries working to articulate a "dream" of a system. The leader of this group is Rob Reiner, who began to visualize an early childhood infrastructure for our state in the 1980s, when we were in the midst of major budget cuts. First 5 California spokesperson Ben Austin has defined a visionary as "a person who is able to see around corners" (personal communication). Rob has that ability. He believes in politics as an agent of change, and is committed to the idea that, through strategic thinking, resources can be located to do what is right. Rob pushed us to think big, and ultimately the UPK initiative was passed. Project director Karen Hill Scott and her staff will develop the implementation plan. We have chosen two proven leaders to act as co-chairs of our UPK Initiative: Robert Hertzberg and Nancy Daly Riordan. As former speaker of the Assembly for the state of California, Robert Hertzberg believes in the importance of attracting bi-partisan political support to the UPK work group. He is particularly interested in looking for allies in other than the usual places, saying "This is an issue that affects everyone in the state; our job is to help them see this" (personal communication). Longtime child advocate and former First Lady of Los Angeles, Nancy Daly Riordan has also been highly focused on forming the work group for the initiative. "We have assembled an extraordinary group of visionary leaders, many of whom do not typically focus their energies on the world of children. These dynamic, busy people could not say no to this rare opportunity to participate in creating a new and innovative early education system that will better prepare all our children for happy and productive lives" (personal communication).

"We have assembled an extraordinary group of visionary leaders, many of whom do not typically focus their energies on the world of children. These dynamic, busy people could not say no to this rare opportunity to participate in creating a new and innovative early education system that will better prepare all our children for happy and productive lives."

The implementation plan

We have decided to focus on creating innovative, high-quality programs for the 4-year-olds of Los Angeles County. We will bring the best practices from other states and nations to build a model that will be accessible and viewed as desirable by a large, diverse constituency. We are beginning with 4-year-olds because of the diminishing support for enrolling younger children in a state-sponsored system. In fact, the younger the child, the less public support is available for serving them. Our goal is to create such programmatic excellence that parents will want their children to participate in these programs, regardless of age, and regardless of parental resources. Another "California Dream," perhaps. Will the resulting programmatic and systemic model meet the needs and aspirations of a pluralistic parent constituency? We will see.

In California, we say that if it can be done in Los Angeles County, it can be done everywhere. Hopefully in 10 years, every state that does not have a UPK system will look at ours and accept the challenge of creating its own, saying, "If it can be done in California, it can be done here."

INFANT MENTAL HEALTH EVALUATION PROCESS: EVALUATING, DIAGNOSING, AND TREATING INFANT MENTAL HEALTH IN COMMUNITY PRACTICE

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A growing body of literature shows the negative effects of parents' psychiatric disorders on an infant's emotional development, especially when the family is also enduring psychosocial stress (Landy, 2000; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987; Shonkoff & Phillips, 2000; Zeanah, Boris, & Scheeringa, 1997). Despite the efforts of professionals to provide quality care to high-risk families with mental health symptoms, there is a lack of appropriate resources and formal training in the assessment and diagnosis of infant mental health disorders within the prevailing systems of care (Shonkoff & Phillips, 2000). It is important to note that, without the necessary services the families s. ffer and they burden the overall health care system because of the worsening of untreated and complex problems, and subsequent risks to the developing infant. According to the U.S. Surgeon General, 1 in 10 children and adolescents have a mental health disorder that is severe enough to cause impairment and the increased probability of a disorder starting in infancy is exacerbated by parental psychiatric disorders, poverty, and other psychosocial stressors (Shonkoff & Phillips, 2000).

We report here on an innovative home visitation program that offers a range of health, mental health, substance abuse, and social services within an integrated, community-wide system of care for low-income, high-risk families with infants. The specific purpose of the article is to discuss the mental health team approach to working with the families who are at the highest risk, highlighting the team's infant evaluation process, which we consider serves as a model for others who are developing diagnostic procedures in the field of infant mental health.

The authors wish to acknowledge and thank the families whose participation in the program has inspired us.

The Quality Improvement Committee/Internal Review Board of the Mental Health Services Division in San Mateo County approved this paper. Informed consent was obtained from parents and no identifying information was included to safeguard confidentiality.

Prenatal to Three Initiative: A Model of Service Integration

After extensive community planning and collaboration, San Mateo County, California, launched the Prenatal to Three Initiative in 1996 to support the development of infants and young children during the prenatal and postnatal periods. It is a large-scale public program and community-wide system of care with an applied model of service delivery that has served over 7,000 families since its inception. The Prenatal to Three Initiative of public and private agencies and the Prenatal to Three Program, housed in the public health department, offer to families on Medicaid a range of multidisciplinary and individualized intervention services in their homes and a series of community-wide parent–infant interaction groups, all available until the infant is 4 years old. The primary goals of the program are the early detection and treatment of health and mental health problems, and the prevention of problems as the infant develops.

Three culturally and linguistically interactive teams of professionals and paraprofessionals work with families according to the needs defined by the family: Mental Health High Risk (MHHR) team of licensed psychiatric social workers and family therapists, a licensed clinical psychologist, a perinatal psychiatrist, a child psychiatrist, interns, and trained paraprofessionals; Perinatal Addiction Team of social workers and substance abuse counselors; and Low–Moderate Risk Team of public health nurses, nutritionists, certified lactation educators, and trained paraprofessionals. Families are referred to a centralized registration system and were offered a first home visit by a public health nurse who assesses their needs. If a history of

parental mental illness, current symptoms of mental distress, family violence, or substance abuse is suspected or disclosed during the first or subsequent home visits, the family is referred to the MHHR team or the Perinatal Outreach Addiction Team. When there are substance abuse and mental health concerns, the family is managed by both the Perinatal Addiction and MHHR teams.

The Prenatal to 3 MHHR Team

In nearly 80% of the families served by the MHHR team at least one parent (usually the mother) has a mental health problem and their identification is the result of in-house assessment and referral. This case finding process has helped to identify mothers who have untreated symptoms of mental distress during pregnancy or right after delivery and who may not have had access to mental health services. Unlike the prevailing mental health treatment model, which primarily addresses the psychopathologies of the mothers, the MHHR treatment model considers the effects that maternal psychiatric disorders have on the infant's emotional development (Gelfand & Teti, 1990; Schore 1997; Seifer & Dickstein, 1993). Infants who are suspected of emotional distress, relationship problems, or regulatory problems, and were born medically fragile, preterm, or with birth trauma receive a comprehensive and strength-based mental health evaluation. In compliance with California Senate Bill 933, infants and young children under age 5 years who are part of the Child Welfare System and in shelter care in San Mateo County receive a mental health evaluation.

The MHHR clinicians are cross-trained in adult and infant psychopathology and mental health assessment. They come to the Prenatal to Three Program knowing adult and child mental health assessment using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994), and continue to receive instruction in perinatal mood disorders, substance abuse and dual diagnosis, domestic violence, infant attachment, early brain development, neurobehavioral and developmental concepts, early relationship-based interventions, and methods for treating young traumatized children. Qualified individuals from either the MHHR team or San Mateo County Mental Health provide some of these trainings, and others are offered through seminars or specialized courses. All of the mental health clinicians have advanced their knowledge of infant assessment and diagnosis through intensive workshops that include the Family Infant Relationship Support Training (FIRST; Browne, MacLeod, & Smith-Sharp, 1999); Parent–Child Interaction Rating Scale (Crnic, Greenberg, Ragozin, Robinson, & Basham, 1983); Ages and Stages Questionnaire (ASQ; Bricker, et al., 1995); Diagnostic Classification: 0–3 (DC 0–3; Zero to Three, 1994); and Infant and Toddler Mental Status Exam (Thomas et al., 1997). The child psychologist came to the program already certified on the Neonatal Assessment Scale (NBAS; Brazelton, 1984), the Assessment of Preterm Infant Behavior (APIB; Als, Lester, & Tronick, 1982), and the FIRST. She is a FIRST trainer and works with the staff to become certified on this observation tool.

The MHHR Infant Treatment Model

The MHHR team developed an evaluation and diagnostic process for the infant that is consistent with the principles of appropriate developmental assessment practice (Greenspan & Meisels, 1994). The primary purpose is to achieve an understanding of the infant's competencies and areas of need, with these results then used: to identify infants with a mental health disorder; to recognize a relationship disorder between the infant and primary caregiver; to detect mothers with a mental health disorder early in the perinatal period; and to formulate effective treatments. When a family is referred to the MHHR team and the infant is suspected of having an emotional or behavioral disturbance, either a psychiatric social worker or a licensed family therapist working in consultation with the child psychologist initiates the infant assessment process. The clinician has 60 days to do a formal infant mental health evaluation and make a diagnosis. As outlined in Table 1, the mental health treatment process consists of relationship building, observation, assessment, diagnosis, and intervention.

The first step is for the clinician to establish a relationship with the family and focus on their strengths. The clinician will informally observe the infant and the primary caregiver, who is usually the mother, interacting in the home environment while the community worker appraises the family's social supports and resource needs. As the relationship develops and trust is established, the clinician conducts a family clinical interview that includes a history of any psychiatric disorders, substance abuse, or family violence, and the infant's health and development. If either parent exhibits symptoms of serious mental distress, a referral is made to the MHHR perinatal psychiatrist for a medication evaluation and/or hospitalization, which is followed by home psychotherapy. The clinician next formally observes the quality of the caregiver–infant relationship using the FIRST tool for infants, age birth to 6 months (Browne et al., 1999) and the Parent–Child Interaction Rating Scale (Crnic et al., 1983) for older children.

At the next phase of the treatment, the clinician, working in partnership with family, administers ASQ to assess the infant's developmental status and to identify areas of vulnerability. Subsequent questionnaires are performed every 4 months to assist intervention efforts and to prevent problems from escalating or new ones from occurring. When an infant does not score within expectation on the

ASQ, a referral is made to the MHHR psychologist or other community or state agencies for additional testing. At this time the clinician completes a formal infant mental health evaluation that integrates information from the assessment findings, the infant mental status examination, and sleeping and feeding routines, obtained from the interview with the caregiver, to form a holistic view of the infant.

The next phase in the process is for the clinician to discuss the assessment findings with the larger mental health team at weekly diagnostic meetings. The team's added contributions are a potent source of a more valid interpretation of the assessment findings that permits for the formulation of an infant mental health diagnosis using both the DC 0–3 and DSM-IV classification systems, and effective intervention strategies. Individual treatment planning done in conjunction with the family focuses on the strengths of the infant, of the primary caregiver, and of their relationship, as well as the interactions among all family members and other community support systems. Interventions for the infants include individual therapy with a MHHR clinician and recommendations for additional services when warranted. If the primary caregiver has a serious mental illness or is exhibiting signs of depression or psychosis, immediate interventions are implemented to stabilize symptoms of mental distress with hospitalization and/or medication management and home psychotherapy. If the infant or the caregiver or both have a mental

TABLE 1: MENTAL HEALTH HIGH RISK ASSESSMENT AND INTERVENTION PROCESS

Curricular Areas	0–5 Months (Infant)	6–48 Months (Infant)	Parent
Step 1 Relationship building	Home visits	Home visits	Appraise resources and social support
Step 2 Observation period	First observation	Parent/infant play interaction	Family clinical interview
Step 3 Assessment period	ASQ: >2 months Bayley Scales II mental health assessment	ASQ Bayley Scales II mental health assessment	Mental health assessment; psychiatric evaluation if warranted
Step 4 Diagnosis and evaluation	DC 0–3 DSM-IV	DC 0–3 DSM-IV	DSM-IV
Step 5 Intervention	Individual family treatment plan High risk team for: individual therapy and parent-infant relationship support Added assessments and/or early infant services if warranted Wrap around services if warranted	Individual family treatment plan High risk team for: individual therapy and parent-infant relationship support Added assessments and/or early infant/school district services if warranted Wrap around services if warranted	Individual family treatment plan High risk team for: individual therapy and parent-infant relationship support Therapy plus medication management if warranted Wrap around social services if needed

ASQ: Ages and Stages Questionnaire; **FIRST:** Family Infant Relationship Support Training Observation Tool; **DSM-IV:** Diagnostic and Statistical Manual of Mental Disorders; **DC 0–3:** Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood

health disorder, early and ongoing relationship-based interventions with both are aimed at helping the caregiver to be emotionally available to the infant and at supporting their relationship in the context of meaningful caregiving routines and shared infant-centered activities.

Case Studies

Regulatory disorder: Type I: Hypersensitive. The public health nurse from the Prenatal to Three program referred John to the psychologist for an evaluation at 4 months of age. John was born full-term with an uncomplicated delivery to young parents who had requested the evaluation because they were concerned with his extreme irritability, poor weight gain, and erratic sleep patterns. The mother, Patricia, considered John a healthy baby, but these problems were straining their relationship and her confidence in her ability to soothe and comfort him was decreasing.

Evaluation

The first phase of the evaluation process was to establish a relationship with the family and focus on their strengths. The parents' support for each other and their ability to express areas of concern and needs, as well as to establish rapport with the psychologist, were considered strengths. As the relationship with the family evolved, the psychologist formally observed Patricia and John interacting during feeding and caregiving activities, using the FIRST observation. Completing the observation allowed the psychologist to gain an understanding of John's behavior and to identify problems in his regulatory system that were influencing the relationship with Patricia. John had a low tolerance for stimulation and was easily overwhelmed by his mother's voice, the noise from the stereo, and abrupt movements. He would fall asleep from exhaustion and then wake up 15 minutes later still in a fussy and irritable state, not wanting to eat and crying excessively as Patricia tried to soothe him.

Following the FIRST observation, the psychologist discussed with Patricia that the feeding was very demanding for John and that she observed him reacting to Patricia's voice and other sounds in the environment. Together, they listed behaviors that John used to signal overstimulation and signs of disorganization, which included increased rapid breathing, squirming, and fussiness. The process of going over these behaviors allowed Patricia to reflect on the infant and their relationship, and to share her own observations and concerns. Patricia stated that John was hard to understand and that she felt inadequate as a mother, compared to her own mother who was able to feed and soothe him. The psychologist reassured Patricia about how much she was doing to care for John and that structuring the caregiving environment to better support his behavior and self-regulation could enhance their interactions. The psychologist helped Patricia create a quiet, soothing place and showed her how to alter the feeding to be less stimulating. Her recommendations to Patricia included lowering the music and her voice, feeding John with a slower pace, decreasing rapid movements, and providing more containment to diminish the likelihood of excess stimulation. The psychologist suggested that Janet loosely swaddle John and hold him closer to her body, as well as offering him a pacifier just prior to feeding to help him become more organized and a finger to grasp during feeding that would support his own self-regulatory efforts.

The psychologist scheduled a series of home visits so she could monitor John's sensory needs, evaluate his development, and support the mother–infant relationship. An assessment on the Bayley Scales of Infant Development II (Bayley, 1993) at 5 months old highlighted John's strengths, which included developmental milestones that were within expectation for his age and intermittent periods of social responsiveness, along with signs of excessive irritability, persistent poor weight gain, and erratic sleep patterns. By now trust with the mother had deepened and the psychologist completed the family clinical interview. Through this guided interview Patricia disclosed her own fear of gaining weight and a history of an eating disorder during adolescence when she was barely eating and lost a significant amount of weight. Patricia revealed feeling inadequate around her own mother, who was critical of Patricia's ability to parent John. As a result, Patricia found herself becoming more anxious and increasing her own expectations of her parenting and how John "should be," which was putting an even bigger strain on their relationship.

Diagnostic Process

The psychologist discussed the assessment findings at the diagnostic meeting with the MHHR team. The team ruled out primary eating and sleep disorders and agreed that the underlying basis for John's eating and sleeping difficulties was regulatory problems. These were John's reactivity to sounds and touch, extreme irritability, poor eating and sleeping, and poor self-regulation and self-comforting. The team recognized that the environment lacked support due to the mother's anxious and tense relationship with John. Exacerbated by her feelings of inadequacy in parenting John in comparison to the grandmother, Patricia had increased her expectations of herself and of John. And although these interactions contributed to his behavior and the environment was not supportive of his difficulties, the team decided that he had clear constitutional difficulties and sensory patterns characteristic with an Axis I hypersensitive regulatory disorder made worse by an Axis II disordered primary caretaking relationship that was

anxious and tense. John's diagnostic summary is presented in Figure 1.

Intervention

The psychologist, working in conjunction with the family, designed a treatment plan with a multidisciplinary approach that included individual therapeutic interventions for John and his mother and relationship-based interventions to support their interactions. For John, treatments included consultation with Patricia by a nutritionist from the Prenatal to Three Program to discuss his nutritional needs, a recommendation to an occupational therapist, and ongoing home visits with the psychologist to support his emotional and cognitive development and reinforce the treatment goals. The importance of consistent caregiving and methods to regulate sensory input to create a calm environment containing minimal distractions and transitions, which interfered with John's regulation, were emphasized. The nutritionist and Patricia discussed nutrition and ways to make the feeding experience developmentally appropriate and child-centered. As John aged, the nutritionist encouraged Patricia to allow him to take a more active role in the feeding by exploring and experimenting with different foods. Strategies that John could use to self-soothe were introduced early on in treatment by the psychologist and were revised and updated to support his increasing behavior organization. The psychologist worked with Patricia to determine the amount of emotion arousal that John could tolerate without becoming disorganized and gradually expanded the level of arousal he could tolerate by slowly introducing more stimuli.

Individual therapeutic work with Patricia centered on providing acceptance and nurturance, which enabled her to express negative feelings about herself and her relationship with John and helped to reduce the anxieties she was feeling. Patricia was encouraged to find ways to restore her energy and do things for herself so she could be more available to meet John's needs and demands. By drawing upon her strengths as a devoted mother, Patricia was able to develop her own unique parenting style, which built her confidence and transferred to her feeling less threatened by her own mother.

Early relationship-based interventions for John and his mother focused on improving their interactions in the context of meaningful caregiving and shared infant-centered play activities. By playing with John, Patricia was better able to observe his abilities and strengths, and to be more aware of stress cues which signaled his need for less stimulating interactions. She designed a quiet play space where they enjoyed activities such as reading picture books, which John used to help focus his attention and self-soothe and which brought joy to both of them. Following several months of therapy, it was suggested that John and Patricia attend a playgroup that could support more pleasure and successful interactive learning with other mothers and infants. It was thought that he would enjoy the opportunity to explore and play with other children and she would receive the support of other relationships. After 1 year of receiving

FIGURE 1: DIAGNOSTIC SUMMARY: REGULATORY DISORDER: HYPERSENSITIVE

DC: 0–3	Code	P/S	DC: 0–3	Code	P/S
Axis I (Primary)			**Axis I (Primary)**		
Regulartory disorder: Hypersensitive	401	P	Disruptive behavior disorder not otherwise specified	312.9	P
			Parent/child relationship problem	V 61.20	S
Axis II (Caregiver)			**Axis II**		
Relationship disorder: Anxious/tense	903		None		
Axis III (Medical and developmental)			**Axis III** (Developmental disabilities and physical health disorder)		
None			None		
Axis IV (Psychosocial stressor)			**Axis IV (Psychosocial stressor)**		
Mother's history of eating disorder Mother/Maternal grandmother problem			Mother's history of eating disorder Mother/maternal grandmother problem		
Axis V (Functional, emotional, developmental level)	has not achieved expected level but all prior levels		**Axis V** GAF (Current functioning)	51	
PIRGAS (Parental, relational, global assessment)	Disordered:30				
Differentials			**Differentials**		

both individual and group therapy, John's relationship and interactions with his mother improved and his eating and weight gain increased. Patricia returned to work and was no longer eligible for services, but she remained in contact with the psychologist. While John continued to have difficulty regulating his behavior and interacting with his peers, his mother reported being able to support him. Patricia felt better about her parenting, compared herself less to her own mother, and was working with her to care for John.

Traumatic stress disorder. The community worker from the MHHR team referred Laura to the clinician for an evaluation when she was 3 months old. Laura was born at term with an uncomplicated delivery following a stressful prenatal period marked by domestic violence. Since the baby's birth, the violence had escalated both in terms of verbal arguments and physical fights. And although Laura's mother, Christine, thought Laura was growing normally, she asked for mental health services because she feared the violence would impact Laura's development and their attachment relationship.

Evaluation

In the initial evaluation period the MHHR clinician attempted to build a relationship with the family and to observe Laura in the home environment. Christine wanted to learn how to create a healthy family environment so Laura could feel secure and develop appropriately. Building upon this strength, the clinician informed the mother about the importance of the early years for Laura's emotional and general development. In the beginning stages of the evaluation, Christine provided history about the family dynamics and her own emotional status. She disclosed feeling a tremendous amount of stress during pregnancy when Laura's father hit her, which resulted in poor appetite and weight loss. After Laura was born, she was exposed to increasing episodes of violence whereby her father would approach her mother in fits of anger while Laura was being held. There were a few times when he aimed his punch towards them but then hit the wall. On one of these occasions something fell and barely missed Laura's head. Sometimes when Christine was upset with the father she would scream at him, but only if Laura was in the other room either sitting in a swing or asleep. The most salient feature of these early visits was that Christine's strong desire to protect Laura was outweighed by the overwhelming need to discuss her own situation, even as the baby often sat silently in a fast-moving swing. At 3 months of age, a baby is expected to seek her mother's eyes and smile and vocalize in response to her face and voice, but Laura's states mostly ranged from drowsy to light sleep, and she had little energy to attend or protest.

As Christine gained confidence with the clinician, this relationship allowed for more contact with Laura and more opportunities to see the mother and baby together. From the observations, it was evident that Laura responded best to her mother when held securely in Christine's arms. If the mother talked quietly to arouse Laura to an alert state, she was able to smile and turn to localize Christine's voice. However, in these instances Christine's face often grew sad as the need to discuss her situation overcame the opportunity to interact with Laura, who would become either glassy-eyed or exhausted and give up trying to elicit her mother's attention. Even when lying on her back playing with a mobile with her arms extended to the side and her breathing increased, Laura became immobile and fell asleep after a few jerky attempts to bat the toys. This was the point in the evaluation when the clinician was able to approach Christine with issues regarding Laura's development and their interactions in an attempt to shift the mother's attention away from herself and to the baby. The relationship with the mother deepened when the clinician pointed out how Laura had responded positively to Christine's voice with smiles and made efforts to seek her attention.

In the visit that followed, the clinician assessed Laura's behavior and development with the MHHR psychologist, who engaged Laura in some floor time play. Laura did not cry or protest when placed on her stomach even though this was a new position and she seemed uncomfortable. When lying supine and playing with hanging toys, Laura brightened and vocalized in response to a musical toy, which helped her attention and brought faint joy to her face. The psychologist next observed the mother and baby interacting during a bathing activity, using the FIRST observation. Laura did not react to being undressed and placed in the water where she sat quietly without protesting or making pleasurable sounds, except on one occasion when she smiled in response to her mother's face and voice. Over a prolonged period of subsequent caregiving activities within this same visit, Laura did not babble and did not cry until 1 hour later. The mother now shared her own observations and concerns about Laura. She disclosed a serious domestic dispute had occurred earlier in the week, just prior to the FIRST observation. Christine reported being the only one hurt, but she described recent changes in Laura's behavior that included increased startles, sleep, and irritability, and decreased eating. Moreover, she was beginning to see Laura reacting to the domestic violence by withdrawing and "going into her own little world" and noticed these same behaviors earlier during the bath and when Laura was introduced to new people and settings.

Diagnostic Process

The clinician discussed the assessment findings at the diagnostic meeting with the MHHR team who judged that Laura's symptoms were consistent with the diagnosis of Traumatic Stress Disorder. Her traumatic experiences began in utero when her mother was physically hurt and continued after

birth with a series of increased verbal arguments and physical fights. The most recent incident had occurred when Laura was in Christine's arms and both of them were pushed to the floor and wedged in between a heavy object and the floor. Once released, Christine was kicked and hit while Laura lay still in her arms. In the week following this incident, the clinician made a home visit and found Laura crying uncontrollably in her mother's arms for at least 50 minutes. Laura was obviously tired as her head fell and eyes closed, but was abruptly awakened by a startle and increased fussiness and crying that was impossible to soothe. Christine stated that Laura had begun crying earlier that day after the parents had a verbal argument and that in the past week she'd woken up screaming and crying for long periods of time. Laura was no longer quieting to her mother's voice or touch, or to the sound of music; all of which helped to soothe her in the past.

The symptoms reported by the mother and observed by the clinician that were suggestive of traumatic stress included: a) Laura becoming sensitized to the violent episodes and freezing was observed when she grew still and retreated, or dissociated into her own little world, during the fights and when introduced to new settings or people; b) numbing of responsiveness and interference with developmental energy, manifested by social withdrawal and a decrease in the capacity for pleasure, a disruption in her vocalizations, and a constriction in play; c) symptoms of increased arousal, including startles, irritability that was becoming more uncontrollable and difficult to soothe, and sleep disturbance; and d) signs of increased and more acute episodes of anxiety.

In light of the relationship between the stress brought forth by Laura's witnessing multiple instances of increased violence between the parents and feeling threatened by these incidents, an Axis I diagnosis of Traumatic Stress Disorder was considered primary. Although the MHHR team discussed a possible regulatory disorder, it questioned to what extent Laura's decreased arousal and restricted range of emotions would be present without a constitutional factor she not enduring chronic stress. The frightening nature of the violence and the duration of increased symptoms made the diagnosis of an adjustment disorder inappropriate. In observing the relationship between Laura and her mother, the team identified an Axis II diagnosis of a mixed pattern of underinvolved and anxious/tense interactive behavior that appeared more than transient. On the one hand, Christine appeared overly anxious to care for Laura, and on the other hand, she had trouble recognizing Laura's appropriate bids for attention. It seemed that Christine's constant fear and endurance of abuse left her without sufficient energy which caused difficulty in providing appropriate ways to care for and interact with Laura. The diagnostic summary is presented in Figure 2.

FIGURE 2: TRAUMATIC STRESS DISORDER

DC: 0-3	Code	P/S	DC: 0-3	Code	P/S
Axis I (Primary)			**Axis I (Primary)**		
Traumatic stress disorder	100	P	Post traumatic stress disorder Parent–child relationship problem	309.81 V 61.20	P
Axis II (Caregiver)			**Axis II**		
Mixed relationship disorder: Underinvolved/anxious/tense	905		None		
Axis III (Medical and developmental)			**Axis III** (Developmental disabilities and physical health disorder)		
None			None		
Axis IV (Psychosocial stressor) Severe effects			**Axis IV (Psychosocial stressor)** Severe effects		
Axis V (Functional, emotional, developmental level)	has not achieved expected level but all prior levels		**Axis V** GAF (Current functioning)	30	
PIRGAS (Parental, relational, global assessment)	Disordered:30				
Differentials Mood disorder: Depression of infancy and early childhood	203		**Differentials** Depressive disorder not otherwise specified	311	

Interventions

The treatment plan included crisis interventions and referrals to the San Mateo County Police and the Social Service departments to assure the safety of Laura and her mother. The police were called upon to make a well-baby check after Christine disclosed being hit by the father when Laura was in her arms. At this time Child Protective Services required the father to move out of the house and made a safety plan with the mother to seek police intervention should there be any more violent episodes. Given that the mother expressed a strong interest in maintaining the relationship with the father, the child welfare worker arranged for the parents to attend anger management classes, to ensure a safer family environment, and couple's counseling, and also offered respite and child care assistance for Laura.

The MHHR clinician, working in conjunction with the mother, designed a multidisciplinary treatment plan that included individual therapeutic interventions for Laura and Christine that met each one's needs, and relationship-based interventions to strengthen their interactions. Individual treatments included well-baby checks with the public health nurse from the Prenatal to Three Program and weekly home visits with the clinician. Because dealing with the trauma coincided with Laura's expectable developmental challenges, interventions focused on supporting new skills in the areas of motor, cognitive, language, and social-emotional development, as well as learning how to cope with stress in appropriate ways. The clinician encouraged Christine to play with Laura on the floor and to try different positions on her stomach and back to strengthen Laura's gross motor development and facilitate her reaching behaviors. A regular reading practice was integrated into the treatment to elicit positive emotions and interest from Laura and to support her early language development. Christine was encouraged to sing and talk to Laura more often, and to repeat her sounds. The clinician discussed that these play interactions, combined with consistent and predictable caregiving routines, would help reduce Laura's stress, and introduced the idea of a range of activities from arousing to soothing to help Laura sustain alertness and support her own self-regulation and coping skills. The clinician's recommendations to the mother included using more quiet containment and Laura's blanket as a transition object to soothe her when she got very upset and could not quiet, and she shared knowledge that the experience of violence poses serious, long-lasting threats to an infant's development.

Early relationship-based therapy with Laura and her mother focused on each one's strengths and on developmental guidance that could help Laura break through the trauma and safely express her emotions. At each visit the clinician pointed out when Laura responded positively to her mother's voice with smiles and tried to seek her attention. Christine was made aware that expressing her strong emotions in the presence of her daughter caused Laura to withdraw and therefore should be limited. Together the clinician and mother listed Laura's stress cues, which included being still and quiet, retreating into her own world, inconsolable crying, and disruptive sleep, and encouraged Christine to respond early to these signs of distress during caregiving and to alter the interaction as needed for the baby to be able to engage with her. Christine was encouraged to watch for Laura's delayed reactions to stress which may occur during sleep or when she is crying uncontrollably, and to remain with Laura until she showed more stable and organized physiologic and motor behaviors. The practice of going over these behaviors enhanced the mother's awareness and made her more responsive in helping Laura to attain and maintain pleasurable states of excitement and transition into calm states before going to sleep. The mother began to see that providing the baby with eye contact and cuddling supported Laura's own efforts to self-regulate.

Individual therapeutic work with the mother centered on providing nurturance to help her reduce anxiety and cope with stress in ways that would not interfere with her relationship with Laura, and providing respite child-care as needed to help reduce her stress. The clinician referred Christine to the psychiatrist from the Prenatal to Three Program for an evaluation and ongoing medication management, and provided counseling for Christine that focused on her own trauma and on how to address the violence with Laura's father. The topic of reunification with Christine's own mother was discussed, in the hope that this emotional connection would make Christine feel more secure and allow for more focus and for organized thinking about the future. When the mother expressed how nice it would be to have someone think about how she was doing, the clinician helped her to understand that Laura too experienced this same kind of relief when her needs were recognized. During a home visit, Christine announced that she and Laura were going to visit the grandmother for 2 weeks, knowing that this would allow the baby to be in a more stable family environment. They have since returned and re-established contact with the clinician to continue treatment. With the added support systems offered to the family by the Prenatal to Three Program, there has been an increase in positive communication between the parents. They are currently working on their relationship and are more focused on supporting each other's needs and on being emotionally involved and available to meet Laura's needs as well.

Prenatal to Three MHHR Team Research Study

The Early Periodic Screening and Diagnostic Treatment mandates a DSM-IV diagnosis for reimbursement of infant mental health services, but the MHHR team has received a

Table 2 Comparison: Diagnostic Classification 0–3 and DSM-IV for Infants and Young Children

Axis I DC 0–3	N=142	Axis I DSM-IV	N=142
Traumatic stress disorder	17.6%	Posttraumatic stress disorder	17.6%
Anxiety disorders of infancy and early childhood	1.4%	Generalized anxiety disorder	1.4%
Mood disorder: Prolonged bereavement/grief reaction	2.8%	Adjustment disorder with depressed mood	2.8%
Mixed disorder: Depression of infancy and early childhood	7.0%	Depressive disorder not otherwise specified	7.0%
Mixed disorder of emotional expressiveness	1.4%	Dysthymic disorder not otherwise specified	1.4%
Reactive attachment deprivation/maltreatment disorder of infancy and early childhood	5.6%	Reactive attachment disorder of infancy or early childhood	5.6%
Adjustment disorder	34.5%	Adjustment disorder: Unspecified	34.5%
Regulatory disorder: Hypersensitive	7.0%	Disruptive behavior disorder not otherwise specified	7.0%
Regulatory disorder: Under-reactive	1.4%	Pervasive developmental disorder not otherwise specified	1.4%
Regulatory disorder: Motorically disorganized, impuslive	5.6%	Impulsive control disorder not otherwise specified	5.6%
Regulatory disorder: Type IV mixed	2.8%	Disorder of infancy, childhood, or adolescence not otherwise specified	2.8%
Sleep behavior disorder	2.0%	Circadian rhythm sleep disorder	2.0%
Eating behavior disorder	3.5%	Feeding disorder of infancy or early childhood	3.5%
Disorders of relating (L-C)	7.0%	Pervasive developmental communicating disorder not otherwise specified	7.0%
Axis II DC 0–3 relationship disorders	**N=22**	**Axis I DSM-IV (V Codes)**	**N=22**
Overinvolved Underinvolved Anxious/tense Angry/hostile Mixed relationship disorder	4.5% 22.7% 22.7% 0% 31.8%	Parent/child relational problem	82.0%
Abusive	18.0%	Physical abuse	18.0%

Axis I DSM-IV	N=6		
Developmental coordination disorder	66.7%	Pica	16.6%
Phonological disorder	16.6%		

waiver from the State of California to use the DC 0–3 as long as it crosses over with a DSM-IV diagnosis. Permission was granted to use this process because clinicians who use only the DSM-IV might not identify specific constitutional/maturational, affective, or traumatic risk factors recognized by the DC 0–3 (Thomas & Guskin, 2001). However, the DC 0–3 does not include all possible mental health disorders in infants and young children, meaning that the MHHR clinicians also reference the DSM-IV. In this way the likelihood of early identification of mental health disorders is improved and the first step toward treatment is taken. Through the MHHR diagnostic process, a comparison template of the DC 0–3 and DSM-IV was created (Perez, Pfeifer, & Newman, 2002) and is currently being field-tested to examine where the DC 0–3 diagnoses lead and whether they are premorbid patterns for later mental health disorders (Nottelman & Jensen, 1995; Thomas & Guskin, 2001). The crossover between these two diagnostic systems may not always be accurate, but it does offer a starting place to determine whether we can identify early on behavioral and emotional disorders that may appear later in life.

The percentage of infants and toddlers who have met diagnostic criteria for a mental health disorder on the DC 0–3 and compared with a DSM-IV is depicted in Table 2. The data show that 142 (29.7%) of the 477 children under age 4 years who received an assessment by a MHHR clinician had an Axis I DC 0–3 mental health diagnosis that crossed over with an Axis I DSM IV diagnosis. Of those who met diagnostic criteria on the DC 0-3, 34.5% had adjustment disorder, 18.2% had some kind of affect disorder (including the 5.6% that had reactive attachment deprivation/maltreatment disorder), 17.6% had traumatic stress disorder, 16.8% had some type of regulatory disorder, 7% had disorders of relating, 3.5% had eating behavior disorder, and 2% had sleep behavior disorder. As shown in Table 2, these disorders are depicted alongside a DSM-IV diagnosis derived from the MHHR team's comparison template. Among those 142 children, 22 (15.5%) had an Axis II DC 0–3 relationship disorder that compared with an Axis I DSM-IV parent–child relational problem. An additional 5 (1%) of the 477 children under age of 4 years who received an assessment by a MHHR clinician had an Axis I DSM-IV that did not cross over with a DC 0–3 diagnosis.

In conclusion, the diagnostic data indicate that approximately one third of the infants referred to the MHHR team presented with symptoms severe enough to warrant a diagnosis and receive immediate individualized therapeutic treatments and early relationship-based interventions. These findings suggest the capacity of the MHHR clinicians to identify and treat infants with mental health disorders within the natural environment. Some may not have been offered services or treatment options in the children's prevailing system of care. Although we believe that the early intervention services they are receiving will decrease the severity and progression of emotional disorders later in their lives, longitudinal research evidence and comparison of the DC 0–3 and DSM-IV diagnosis over time is warranted.

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CHANGE AT TUESDAY'S CHILD: A STORY OF TRUST AND LEARNING

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In a course on educational leadership that I took several years ago, the professor encouraged us not to be afraid of championing change in our educational setting. He talked, rather, about how *productive* change could be. We studied theories, read books, and saw films, all of which focused on how changing old ways – and introducing fresh ideas — brings growth and success to organizations. There may be some truth to this idea. But in my experience, change takes place neither as easily nor as quickly as my teacher led us to believe.

An Opportunity To Make Change

About 2 years ago, I became the director of Tuesday's Child, a small non-profit agency in Chicago that served young children (15 months through 6 years) with behavioral difficulties and their families. Six years prior to my appointment, I had been a client parent in that very organization's parent/child intervention program. This program, which was based on the principles of Applied Behavioral Analysis (ABA), had helped my family understand and deal with my son, who had been diagnosed with autism. The intervention had influenced my life to such an extent that I had begun pursuing a graduate degree in early childhood/special education, and later a degree in child development.

As a doctoral candidate at Erikson Institute, I learned about theories of child development and intervention that differed from the ABA approach. Over time, I formed my own ideas of what would be an effective intervention program. Although I still believed in the usefulness of the behavioral model, I also believed that there was much more to intervention than just "stimulus–response." As a way of improving existing programs at the agency, I planned to introduce other ideas and theories. Short after my appointment as director, I had the chance to design and establish a new Birth to Three program. I thought that this effort would not only add a prevention component to the agency's intervention programs, but it would also give me an occasion to introduce new ideas and initiate change in the organization as a whole.

The Existing Model

From the time of its founding, Tuesday's Child had tried to accomplish its mission of improving parent–child relationship by changing parental behavior, and hence changing the child's behavior through the principles ABA. This approach was designed to decrease the number of negative interactions between the parent and the child.

As a client parent, I remember going through weekly mechanical parent–child interaction sessions while a peer parent trainer observed and — using a stop watch and a notebook for recording — measured change in specific behavioral repertoires in me and my child. With most children and families, the intervention succeeded. As a consequence, there was no significant change in the agency's theory or practice for more than 20 years.

I, however, had changed. As a consequence of my years of graduate education, I no longer believed in a single method of practice. Instead, I had become convinced that an in-depth understanding and knowledge of child development, and related theories and practices, would lead to the use of a variety of approaches to intervention with children and families, based on their specific needs and characteristics.

Meanwhile, during the years when I was in graduate school, staff at Tuesday's Child had become increasingly skillful in the intervention techniques they were using. They had also developed close relationships with one another. Looking back, I realize that I should not have been surprised when staff seemed alarmed by my initial suggestions for change.

Two Years of Professional Development

Reflecting that my own ideas about early intervention had changed as a result of my educational experiences, I steered staff toward professional development and educational opportunities. During my first year as director, we held more than 18 in-house in-service programs and staff trainings, had regular weekly staff meetings, and participated in several local and national conferences. Slowly and gradually staff resistance to change diminished. Eventually, staff members became enthusiastic about learning more. They studied early emotional development of infants and young children, attachment, and the Developmental Individual Relationship-Based (DIR) model

of intervention. As staff started to feel more comfortable with these ideas, they began to integrate these ideas into what had been their strictly structured classroom model.

During my second year, I combined several of the most well-known and respected elements of the programs we had studied together. As I began to shape the design of our new Birth to Three program, I discussed it with my staff every step of the way.

Changing Staff, Changing Parents

In time I realized that the staff of Tuesday's Child had to some degree been prepared for change before I became director. In one classroom, for example, the teacher had discovered that calming sensory activities helped children regulate themselves and focus better. In the parent group, two staff members had realized that the behavioral model no longer addressed all of the issues that parents and children were dealing with. To meet families' needs and answer their questions, these staff members had begun to integrate additional areas of knowledge into discussions.

The first-year in-service training sessions, then, helped clinicians and teachers to learn systematically about theories and practices that they had already begun to use intuitively. Gaining theoretical validation for their own responses, clinicians started to openly encourage parents to look at physiological and emotional causes of their children's behaviors. All of us stopped dictating to parents how to shape their children's behaviors and prescribing scripted, mechanical interactions. Instead, as we taught parents how to address their children's difficult behaviors, we helped them discover how to find ways to alleviate — as well as to prevent — these behaviors at the physiological, emotional, nd environmental level. We encouraged parents to play with their children, enjoy the uniqueness of their children, and make their shared time and play therapeutic for their children.

Relationships Abide

At this point, Tuesday's Child's principal intervention program was continuing to serve grateful and enthusiastic parents. The new Birth to Three program, in contrast, was struggling to retain clients. I started comparing the traditional model to the new program. The first obvious difference was that the traditional program was based on a peer-to-peer model of parent training, while the new program featured a professionally led workshop.

I resolved to reflect daily on my work, examining my own feelings, motives, goals, beliefs, and sincerity. Because I had been a client parent at Tuesday's Child, I thought I could understand what parents might think or how they might feel within an intervention system. I searched my mind for memories of my relationships with the teachers and interveners. I remembered details of interactions that had ultimately been instrumental in shaping our family's daily routines and general functioning.

I began to see that our agency had created a culture, an environment, in which all participants and staff feel "at home." Reflecting on the staff's characteristics and motives, I realized that each staff member forms a special relationship with each family. Each parent, in turn, makes unique meaning from their relationship with each intervener and their experience of the intervention. For example, parents value paraprofessional staff members for their wisdom and ability to picture parents' daily struggles in child rearing and family issues. Parents see professional staff members as expert voices to validate, encourage, and support families in their efforts.

Building a relationship-based model of intervention depends on staff members' ability to understand and accept parents. In our case, most veteran staff members have been client parents in the program. Their helping behavior has been acquired naturally, over time; it is marked by total acceptance and compassion for individual family members.

The quality of relationships among staff members is also an important aspect of effective intervention. Like families, staff members come with diverse characteristics and backgrounds. It is not so much a common element — for example, educational background or personal ideology — that helps team members form positive, effective working relationships with one another. Rather it is their common vested interest in families and children. Disagreements are natural among staff members, but their ties are strong enough to withstand discord.

Although our organization has changed in many ways, it has not changed in being shaped, most of all, by the patterns of relationships between people involved. Changes in our way of relating to children and families had begun long before I arrived. New theories and ideas only helped bring into focus a natural evolution of the organization — an evolution grounded in solid relationships among children, families, and staff.

Understanding this evolution helped us understand our new Birth to Three program as well. Using our peer-to-peer training model, one of our bilingual paraprofessionals currently supervises a Spanish Birth to Three program. To our excitement, parents, interveners, and children in this program are building strong relationships with each other. Each day that parents and children brave the sub-zero temperature of Chicago's winter to reach our center, we feel that we must be getting closer to providing an environment where families feel at home. We feel ourselves getting closer to reaching our mission — improving parent–child relationships.

Learning Through Observation: 5 Video Vignettes to Spark Reflection and Discussion

Producer Lisa Zbar, Independent Production Fund; Managing Editor, Claire Lerner, ZERO TO THREE. Available from ZERO TO THREE, P.O. Box 960, Herndon, VA 20172. Tel. (800) 899-4301 or (703) 661-1577. www.zerotothree.org http://www.zerotothree.org. 65 min. Purchase for $64.95 plus shipping and handling.

This video presents five real-life interactions between professionals and families in a variety of settings, including a home visit with a child with special needs and his family, drop off at a child care center, supervision, a home visit with a Spanish-speaking family (in Spanish), and an Early Head Start home visit. After each vignette, a discussion among ZERO TO THREE board members and staff focuses on practice issues that were raised in the video. Discussion questions are included both on the video and in the accompanying booklet, which may be used to spark group discussions or personal reflection.

Diversity.

Produced by Magna Systems, Inc. and Janet Gonzalez-Mena. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286. Van Nuys, CA 91401. Tel. 800-405-8942. www.ChildDevelopmentMedia.com. Purchase for $90 each or $330 for the series of four videos.

This series offers a new way to help child care providers integrate culturally responsive caregiving with developmentally appropriate practices. The goal is to show diverse perspectives and to help open up communications and create powerful new connections with colleagues, parents, and the children themselves.

Diversity, Independence and Individuality. What constitutes good practice? "It depends." Focusing on diverse reactions to scenes of children learning to be independent, this video shows how valuing independence and individuality define teaching approaches as well as feeding, toileting, and napping practices. Examples are not necessarily how "things should be done," but were chosen for their potential to stimulate discussion about important caregiving issues. 30 min.

Diversity: Contrasting Perspectives. Designed to spark dialogue, this video depicts variations on themes of independence, interdependence, and individuality in the delicate issues involved in day-to-day caregiving. What we believe about the best learning environment depends on our experience and our understanding of what children need. For some, early independence is a primary value. For others, interdependence—helping others and being helped—matters more. 30 min.

Diversity and Communication. Role-playing conflicts between parents and early childhood professionals prepare teachers for today's diverse world. Highlighting communication blocks and pointing out ways of creating connection, this video shows sample areas of disagreement (mostly around neatness and toileting) and shows people learning to understand and respect diversity. 30 min.

Diversity and Conflict Management. Going more deeply into conflict–communications issues, this video demonstrates a practical process for conflict management and resolution. Conflict about discipline, children's privacy, and self-feeding is role-played. Subtle power plays can be seen. The only "how to" video of the series, this video lays out a process or structure for ways to open up communications between parents, teachers, and caregivers and to discover mutual understanding and respect. The conflict management process shown is called RERUN (Reflect, Explain, Reason, Understand, Negotiate). 30 min.

Project CRAFT: Culturally Responsive and Family-Focused Training.

Produced by Deborah Chen, Linda Brekken and Sam Chan. Available from Brookes Publishing Co., Inc., PO Box 10624. Baltimore, MD 21285. Tel. 800-638-3775. www.BrookesPublishing.com. 60 min. Purchase video and booklet for $75 plus shipping and handling.

This program explores the subtleties of working with culturally diverse children and families. The tape delves into stereotypes and the media, family values, relationship building, communication styles and language acquisition. Families from various backgrounds, and the early childhood professionals who work with them, share their experiences and feelings about cultural differences, living with a child with disabilities, and negotiating the special education system. Suggestions for improving service delivery and multicultural family support are included. The accompanying booklet—with topical headers, scenarios, key points and handouts—offers questions and activities to facilitate group discussions.

The Art of Listening: Be All Ears

Produced by Learning Seed. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286. Van Nuys, CA 91401. Tel. 800-405-8942. www.ChildDevelopmentMedia.com. 27 min. Purchase for $90 plus shipping and handling.

This video presents listening as a skill that can be learned, practiced, and perfected. It teaches practical techniques for improving listening and presents seven "Laws of Good Listening." It discusses such issues as the value of silence, the need to find interest, the importance of staying out of the speaker's way, how and when to take notes, the role of body language, and the need to "listen between the words." It also explores

how men and women use different "filtering systems" to give the same message completely different meanings.

Being Active at Child Care (2002)

From the Active Me, Healthy Me Series. *Produced by Plum Pictures. Available from United Learning, 1560 Sherman Avenue, Suite 100, Evanston, IL 60210; 800-323-9084. Fax: 847-328-6706, www.unitedlearning.com. Previews are available. Also available in Spanish. 13 min. Purchase $89 for each tape and $255 for the series plus shipping and handling.*

This program emphasizes to child care providers the enormous impact that physical activity plays in the prevention of childhood obesity and its subsequent long-term health risks. The program focuses on the benefits of physical activity for all ages from birth through pre-school. Creative, safe, and age-appropriate activities for infants, toddlers, and preschoolers are demonstrated with an emphasis on helping children make physical activity part of a healthy lifestyle. Mealtimes in child care during which children are exposed to wholesome foods and a creative eating environment are also shown to exemplify the importance of good nutrition and role modeling to healthy eating habits. The importance of establishing good habits now, at an early age, are discussed with a Evanston-based child care center and home care provider; an NAEYC licensed program director, and a pediatrician. Includes teacher's guide and blackline master. *Active Me, Healthy Me Series also includes Being Active During and After Pregnancy* and *Being Active As A Family*. Each program presents physical activity as exciting, fun, easy-to-do, and motivating. Best of all, the benefits can last a lifetime. Closed Captioned.

It's Mine! Responding to Problems and Conflicts. (2003)

Produced by Betsy Evans. Available from High/Scope Press, 600 North River Street, Ypsilanti, MI 48198; 800-40-PRESS; fax: 800-442-4FAX, www.high-scope.org. Video guide included. 40 min. $30 plus shipping and handling.

This video program for adults working in infant and toddler settings shows many strategies caregivers can use to respond sensitively and positively to children's social conflicts. Also covered are ways to keep conflict to a minimum by creating a warm and play-filled environment. Included are strategies for problem prevention, positive limit-setting, and resolving conflicts—strategies that help children begin to develop important social, language, and reasoning abilities. With this support at a very early age, children are on their way to becoming cooperative and caring individuals. This video shows both younger and older babies and toddlers in several High/Scope infant–toddler settings.

PUBLICATIONS

The Cultural Nature of Human Development

(2003) Barbara Rogoff. Oxford University Press, Inc., 198 Madison Avenue, New York, NY 10016. www.oup-usa.com $25.00. Hardcover.

"People develop as participants in cultural communities. Their development can be understood only in light of the cultural practices and circumstances of their communities—which also change." This stance, observes psychologist Barbara Rogoff, is essential to understanding the cultural patterns of human development—the routine ways of doing things in any community, and people's participation in their communities' cultural practices and traditions. Such a stance is particularly important in the study of human development because researchers who have studied a particular group of children have often overgeneralized, claiming that "the child" develops a skill at a certain age, rather than observing that "these children" demonstrated a skill at a certain age. Rogoff rejects the notion of culture as an entity that influences individuals. Instead, she argues that individual and cultural processes are *mutually constituting*: Individuals and generations shape practices, traditions, and institutions at the same time that they build on what they inherit at their moment in history.

Among the topics that Rogoff examines in this volume are infants' biological preparedness to learn through relationships, cultural strategies for child survival and care, patterns of infant–caregiver attachment, the orientation of infants to one caregiver or to the group, developmental transitions (including the unique social status accorded to infants in some cultures) and interdependence and autonomy. Rogoff suggests that all communities can learn from each other without giving up what they value. She cites the experience of immigrants who borrow from the practices of others while building on what is important to them in their own cultural system.

Raising America: Experts, Parents, and a Century of Advice About Children

(2003) Ann Hulbert (Alfred A. Knopf, a division of Random House, Inc., New York, New York, www.aaknopf.com) $27.50. Hardcover.

Biographer, essayist, and editor Ann Hulbert organizes her review of 20th century expert advice to parents around a series of major Washington, DC–based conferences convened over the years. These gatherings tend to ask the same questions: How much power and control do, and should, parents wield over a child's journey from dependence to independence? How much freedom and intimacy to children need, or want,

along the way? What do the answers imply about mothers' rights and responsibilities?

Hulbert observes that each generation tends to produce what she terms a "parent-centered" expert who emphasizes the centrality of nurture and the importance of discipline, and a "child-centered" expert who suggests that the good parent gently lets a child's nature develop. L. Emmett Holt is contrasted with G. Stanley Hall, and behaviorist John Broadus Watson with Arnold Gesell. In recent decades, Hulbert notes, attention has shifted from why parents are failing to how society might help support struggling families. Finally she describes the "social manifestos" of contemporary parent advisors across the child-centered-parent-centered continuum, counting among these *The Irreducible Needs of Children: What Every Child Must Have To Grow, Learn, and Flourish*, by T. Berry Brazelton and Stanley I. Greenspan.

Play To Learn, Learn To Play: Activities for Parents With Children From Birth Through 3 Years Old.

Keith Elaine Packard (Institute of Cultural Affairs. arodgguez@ica-usa.org.) Available in Spanish and Haitian Creole. $15.00 plus $5.00 shipping and handling. Paperback.

This book of more than 100 activities for parents and teachers of infants and toddlers is designed for use in conjunction with the Creative Curriculum in Early Head Start, Even Start, and Migrant Head Start center-based programs. The activities can also serve as a basis for home visitation and group sessions in Healthy Families and other parent support programs.

Each page describes a developmentally appropriate activity in a few words. Simple multicultural line drawings illustrate each activity. What the child can learn from each activity is represented by a selection from among 25 icons that illustrate dimensions of multiple intelligence across four learning domains. Thus when a caregiver lets a baby hold a piece of cloth and chew on it and asks, "Do you like the cloth?" the baby can learn body movement, recognizing language, relationship to things, feelings, and exploration and discovery. Additional dimensions of learning identified in the book include cooperative play; confident action; rhythm, music, and song; alphabet and sounds; recognizing patterns; and creativity, among others.

Promoting Social Communication: Children with Developmental Disabilities from Birth to Adolescence

(2002) Howard Goldstein, Louise A. Kaczmarek, Kristina M. English, Editors (Paul H. Brookes Publishing Co., Inc., P.O. Box 10624, Baltimore, MD 21285-0624, www.brookespublishing.com) $42.00. Paperback.

In this volume, editors Howard Goldstein, Louise A. Kaczmarek, and Kristina M. English posit that social and communication skills are reciprocal; improving one triggers the development of the other. This book explores the complex connection between social and communication skills and applies the latest research to planning social-communication interventions for children with developmental disabilities from birth to adolescence. The first section of the book presents various approaches and models for supporting the development of social skills. The second section offers a chronological approach to promoting social communication from infancy through the school years, including case studies of social-communicative interventions. Written mainly for professionals in education, speech-language pathology, and psychology, this volume summarizes the most current theory, research, and practice on social communication and related issues.

The Social Context of Cognitive Development

(2001) Mary Gauvain (The Guilford Press, 72 Spring Street, New York, NY 10012, www.guilford.com) $23.00. Paperback.

This book examines recent theory and research on the role of social context—including culture, situation, and activity setting—in cognitive development. Author Mary Gauvain takes the view that family, peer, and community factors influence not only what a child learns, but also how learning occurs. Part I of the book describes a social approach to cognitive development, focusing specifically on the social and cultural foundations of cognitive development. Here, the author examines how social processes support and facilitate intellectual growth. Part II concentrates on what can be learned about domains of cognitive development (specifically, attention, memory, problem solving, and planning) when social context is taken into account. Gauvain concludes with an examination of the theoretical and practical utility of a social approach, and discusses how social context can be conceptualized as a mechanism of cognitive change.

Touch

(2001) Tiffany Field (The MIT Press, Five Cambridge Center, Cambridge, MA 02141-1493, 617-253-5643) $22.95. Hardcover.

Tiffany Field, Director of the Touch Research Institute at the University of Miami School of Medicine, explores the role of touch in children's growth, development, and health, as well as for adults' physical and mental well-being. The book begins with an overview of the sociology and anthropology of touching and the basic psychophysical properties of touch. Later chapters report recent research results on the value of touch therapies, including energy methods (like acupuncture or yoga), manipulative therapies (like massage), and amalgams (combinations of both). There is a special emphasis on infant massage.

The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry

(2003) Andres J. Pumariega and Nancy C. Winters, Editors (John Wiley & Sons, 989 Market Street, San Francisco, CA 94103-

1741, www.josseybass.com, 800-956-7739) $80.00. Hardcover.

The handbook asserts that the best way to support at-risk children is with community-based systems of care (SOC). Part One presents the conceptual foundations of systems of care, including an examination of SOC in meeting children's mental health needs. Part Two asserts the great importance of integrating clinical modalities into systems of care. Part Three addresses the challenges and opportunities inherent in serving various populations and settings; one chapter in this section provides a conceptual framework for an early childhood system of care. Part Four discusses the administration and evaluation of systems of care including relationship-building between SOC and governments working in managed care environments, and training child mental health professionals.

On-line Resources

Healthy Minds: Nurturing Your Child's Development

http://zerotothree.org/healthyminds/

What do we know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of seven **Healthy Minds** handouts. Each handout is based on findings from *From Neurons to Neighborhoods*, the National Academy of Sciences report that reviewed what is known about the nature of early child development and the influence of early experiences on children's health and well-being. The study was sponsored by a number of federal agencies and private foundations. **ZERO TO THREE** and the **American Academy of Pediatrics** developed the content of the 7 handouts to complement well-baby check-ups. Healthy Minds handouts and information about *From Neurons to Neighborhoods* can be downloaded from the ZERO TO THREE Web site as listed above.

ZERO TO THREE Offers Resources on Music in Spanish

http://www.zerotothree.org/spanish/

With the generous support of the **MetLife Foundation, ZERO TO THREE** has developed a "Getting in Tune," a brochure on the musical lives of babies. This publication is available in both English and Spanish (*Afinandose*). The ZERO TO THREE Web site features both versions. The supplemental 2-page "Tip Sheet" entitled "The Magic of Music in Child Care" is also available for viewing and downloading. All resources are posted in the Parent Section of the ZERO TO THREE Web site as listed above.

Resources in Spanish from NCCIC

http://nccic.org/spanish/index.html

The National Child Care Information Center (NCCIC) in Vienna, Virginia provides Resources in Spanish (Recursos en Español) in a new section of their Web site. New products in this section include:

-Como los Padres de Familia, Cuidadoras de Niños Pequeños y Maestras pueden Ayudar a los Niños a Aprender (How Parents, Child Care Providers, and Teachers can Help Children Learn)

-Desarrollo Cerebral Infantil (Infant Brain Development)

Desarrollo de los Niños Pequeños (Young Children's Development)

-La Nutrición, la Salud y la Seguridad en Centros Preescolares y en Hogares de Cuidado Infantil (Nutrition, Health and Safety at Child Care Centers and Family Child Care Homes)

Building Strong Families

http://www.buildingstrongfamilies.info/

Mathematica Policy Research's new Web site is designed to keep track of the research emerging from Building Strong Families, an initiative to develop and evaluate programs designed to help interested unwed parents achieve their aspirations for healthy marriage and a stable family life. This Web site is designed to help programs that participate in the evaluation, and other interested parties, learn about the progress of the evaluation and the kinds of services that are being tested. Many materials will be available to the public, but over time, a password-protected Learning Community will also be supported for the Building Strong Families research sites and others directly involved in the evaluation.

Are Married Parents Really Better for Children?

http://www.clasp.org/DMS/Documents/1052841451.72/MarriageBrief3.pdf

Is promoting marriage a good use of public funds to improve the well-being of children? This **Center on Law and Social Policy** research review concludes that research supports the notion that, on average, children do best when raised by two married, biological parents who have a low-conflict relationship. Yet, the report notes, marriage is no guarantee that families will have the emotional and financial resources to raise children well; and most children not living with married, biological parents grow up without serious problems.

Center on Social and Emotional Development

http://csefel.uiuc.edu

The **Center on the Social and Emotional Foundations for Early Learning** is a national center focused on strengthening the capacity of child care and Head Start programs

to improve the social and emotional outcomes of young children.

It has produced a series of five "*What Works Briefs*" that summarize effective practices for supporting children's development and preventing challenging behaviors. The Briefs describe practical strategies, provide references to more information about the practice, and include a one-page handout that highlights its major points. Brief #2 is of particular interest focusing on *Understanding the Impact of Language Differences on Classroom Behavior.*

Just in Time Parenting Information: State Newsletters

http://www.parentinginfo.org/

These age-specific parent information newsletters, produced and distributed by the U.S. Department of Agriculture (USDA) Extension Family Life Specialists, cover the first year of a child's life. Some states cover parenting up to age 5, and some are available in Spanish as well.

The IDEA Child Find Web site

http://www.childfindidea.org/

Through support from the **U.S. Department of Education**, the **Centers for Excellence in Developmental Disabilities Education, Research and Service** at the Universities of Colorado, Connecticut, Hawaii, Montana, New Hampshire, and Vermont have developed a collaborative website to disseminate information about the collective experiences of six directed demonstration projects concerning the early identification of infants and toddlers who may be eligible for Infant and Toddler Program services, Part C of the IDEA. These directed demonstration projects were designed to evaluate strategies that promote the early identification and referral to Part C programs of infants and toddlers. While Part C Child Find is the key focus of the joint web site, many of the projects included collaborative child find efforts with other programs charged with finding and serving young children, including Early Head Start and Head Start programs, Preschool Special Education, and the many other important health, human service and education programs for young children.

Developmental Milestones

The California Endowment has awarded two grants to ZERO TO THREE for *Leaders for the 21st Century*, ZERO TO THREE's leadership development initiative. Grants will underwrite the participation of four early childhood professionals from California who are working on behalf of very young children and their families.

The Irving Harris Foundation has awarded a grant to ZERO TO THREE to establish the Irving B. Harris Award program of the ZERO TO THREE Press. In December 2003, the Editorial Board of the Press will grant awards to the authors of three outstanding book proposals, which will be developed into completed manuscripts by December 2004 and published in 2005. (See page 7 for more details).

ZERO TO THREE Life Member **Edward Zigler** has been elected as a Fellow of the American Academy of Arts and Sciences class of 2003. Zigler, known as "the father of Head Start," is Sterling Professor of Psychology, director of the Bush Center in Child Development and Social Policy, and senior research scientist in psychology. He is a former chief of the U.S. Children's Bureau, and led efforts to institute programs such as Home Start, Health Start, Education for Parenthood, the Child Development Associate program, and the Child and Family Resource Program. Zigler will also be awarded a 2004 Mentor Award for Division 7 of the **American Psychological Association** (APA).

Member of ZERO TO THREE's Board of Directors and Diagnostic Classification Task Force **Robert J. Harmon** was named a "Professional Honoree" at the **Kempe Children's Foundation's** annual gala for his exceptional work at Kempe's Therapeutic Preschool, where he is the director. The preschool treats severely disturbed 3- to 6-year-old abused and neglected children. Dr. Harmon is a professor of psychiatry and pediatrics at the University of Colorado School of Medicine, Director of the Irving Harris Program in Child Development and Infant Mental Health, Director of the Infant Psychiatry Program, and Deputy Editor of the *Journal of the American Academy of Child and Adolescent Psychiatry*.

Ellen Wheatley, a 1999 ZERO TO THREE Mid-Career Fellow, has accepted the position of Administrator of **New Hampshire's State Head Start** program, which includes Early Head Start. Dr. Wheatley is an adjunct faculty member at the New Hampshire Technical Institute and the co-founder and first president of the New Hampshire Association for Infant Mental Health.

Upcoming Issues

July 2003 – ZERO TO THREE Graduate Fellows Virginia Buysse and Lisa Boyce are guest co-editors of this issue, in which more than a dozen Solnit and Harris Mid-Career Fellows from the class of 2001 offer **guidelines for the evaluation of infant–family programs** and discuss the challenges of carrying out meaningful program evaluations in child care, early intervention, mental health, and government settings.

September 2003 – This issue will mark the 25th anniversary of ZERO TO THREE. Seasoned ZERO TO THREE Board members and colleagues who have entered the field more recently will discuss **major trends in infant–family theory, research, and practice**. Contributors include Carol Berman, Linda Eggbeer, Linda Gilkerson, Irving Harris, Robert Harmon, Ron Lally, Joan Lombardi, Michael MacKenzie, Peter Mangione, Cindy Oser, Jeree Pawl, Arnold Sameroff, and Bernice Weissbourd.

November 2003 – Graduate Fellow Joy Browne is the guest editor of this issue, which examines new perspectives on prematurity. Articles will describe recent developments in research and clinical practice, mental health issues related to prematurity, dilemmas in the care of premature babies, lessons learned from long-term follow-up, developments in public policy, and the experiences of parents and other family members.

The Editorial Mission of the *Zero to Three* Bulletin

To provide a forum for thoughtful discussion of important research, practice, professional development, and policy issues in the multidisciplinary infant, toddler, and family field.

The Mission of ZERO TO THREE: National Center for Infants, Toddlers, and Families

ZERO TO THREE is a national nonprofit whose mission is to promote the healthy social, emotional, and intellectual development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf.

www.zerotothree.org

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